

**DONALD MEICHENBAUM'S HANDOUT FOR 2013 THE EVOLUTION OF
PSYCHOTHERAPY CONFERENCE**

ANAHEIM, CA DEC 11-14, 2013

CONTACT INFORMATION

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215 Sand Key Estates Drive
Clearwater, FL 33767**

DONALD MEICHENBAUM PRESENTATION SCHEDULE

I. Wednesday, Dec. 11 2:30-5:30

Workshop 14 – Treatment of Individuals with PTSD and Comorbid Psychological Disorders: A Constructive Narrative Perspective. (PAGES 9-59)

II. Thursday, Dec. 12 8:30-11:30

Workshop 21 – Treatment of Individuals with Anger-control Problems and Aggressive Behaviors: A Life-span Treatment Approach. (PAGES 60-80)

III. Friday, Dec. 13

8:00 – 9:00 am. Dialogue 2

Expertise and Psychotherapy: What are the Core Tasks of Psychotherapy? (with Scott Miller) (PAGES 81-104)

IV. 9:20-10:20 Topical Panel 3- Children and Adolescents (with John Gottman and Mary Pipher) (PAGES 105-258)

V. 10:40- 11:40 Topical Panel 5- Post-traumatic Stress Disorders (with Jack Kornfield, Peter Levine and Mary Pipher) (PAGES 259-272)

Saturday, Dec. 14

VI. 9:20-10:20 Clinical Demonstration 13- Treatment of a Suicidal Patient with a History of Victimization: A Constructive Narrative Perspective (Video). (PAGES 273-274)

VII. 2:30-4:00 Point-Counterpoint 9

**Advanced Techniques of Therapy: Impactful Intervention Jeffrey Zeig- Presenter
Discussant: Don Meichenbaum (PAGE 275)**

**VIII. 4:15-5:45 Point/Counterpoint 1- Trauma, spirituality and recovery
Discussant: Erving Polster, Ph.D. (PAGES 275-358)**

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Page 81. III. Expertise and Psychotherapy: What are the Core Tasks of Psychotherapy

Page 92. A Look Into the Future of Psychotherapy: The Possible Role of Computer Technology

Page 105. IV. Panel Discussion Children and Adolescents (See Handout on Treating Children and Youth with Problems of Aggression, Anxiety Depression/Suicidality and PTSD)

Page 259. V. Topical Panel PTSD -- (See Chapter " The Therapeutic Relationship as a Common Factor : Implications for Trauma Therapy ")

Page 273. VI. Clinical Demonstration Treatment of a Suicidal Patient with a History of Victimization : A Constructive Narrative Perspective

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BRIEF BIO SKETCH

Donald Meichenbaum, Ph.D. is Distinguished Professor Emeritus, University of Waterloo, Ontario, Canada from which he took early retirement 18 years ago. He is presently Research Director of the Melissa Institute for Violence Prevention in Miami, Florida. Please visit the Melissa Institute Website www.melissainstitute.org which has had 2 million HITS worldwide this year. (Click on Author Index on the left side of the Home Page and scroll to Meichenbaum to access other Handouts and Chapters by him).

Dr. Meichenbaum is one of the founders of Cognitive Behavior Therapy and in a survey reported in the American Psychologist, clinicians voted Dr. Meichenbaum, “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 has presented in all 50 U.S. states and internationally.

He has published extensively and his most recent book is Roadmap to resilience (see www.roadmaptoresilience.org).

ROADMAP TO RESILIENCE: A GUIDE FOR MILITARY, TRAUMA VICTIMS AND THEIR FAMILIES

**Donald Meichenbaum
(211 Pages Price \$ 35)**

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References

Order Form (See www.roadmaptoresilience.org)

About The Author

REVIEWS OF ROADMAP TO RESILIENCE

“Meichenbaum’s Roadmap to Resilience guidebook should be in the backpack of every soldier, in the hand of every leader, and on the desk of every clinician.” Bret Moore, University of Texas Health Science Center, San Antonio.

“The Roadmap to Resilience book is really an amazing piece of work. I would recommend this guidebook to all clinicians who work with trauma survivors.” Richard Tedeschi, University of North Carolina, Charlotte.

“Roadmap to Resilience is a MUST READ for any trauma victim and any service member and their family members. Dr. Meichenbaum has hit a ‘home run’ with this guidebook. It is the “go to’ Handbook for psychological health and readjustment.” Sharon M. Freeman, Co-editor of “Living and surviving in harm’s way”.

“The Roadmap to Resilience book will serve as a wonderful resource to read and re-read by those seeking to enrich their own lives and for their loved ones following hardship and trauma. It will also be an invaluable guide for clinicians working with those individuals and their families.” Robert Brooks, Ph.D., Faculty Harvard Medical School.

REVIEW OF MEICHENBAUM’S ROADMAP TO RESILIENCE BOOK

Reviewed by Michael F. Hoyt, Ph.D.
Mill Valley, California, USA

Roadmap to Resilience: A Guide for Military, Trauma Victims and Their Families
Donald Meichenbaum
Clearwater, FL: Institute Press
2012
ISBN 9780969884026 (softcover)
224 pages, U.S.\$41.00 (\$35 for book plus \$6 S & H)

One of the founders of Cognitive Behavior Therapy, voted one of the 10 most influential psychotherapists of the 20th century, a perennial top-rated presenter at the Evolution of Psychotherapy conferences, and Director of the Melissa Institute for Violence Prevention and Treatment (see www.melissainstitute.org), Don Meichenbaum has distilled his intelligence and encyclopedic research knowledge, his wisdom and passion, and his 40 years of experience working with trauma victims to assemble in this extraordinary, user-friendly guidebook vital information to help persons who have suffered trauma (and their friends and family) to cope, recover, and move forward in their lives. The book is a “must-read.”

Meichenbaum defines *resilience* as “the capacity to adapt successfully in the presence of risk and adversity” (p. 3). Although the book has a focus on military personnel, it is widely applicable to the whole range of horrible things that happen to people—natural disasters, interpersonal violence, accidents, illnesses, and losses. As Meichenbaum notes, over the

course of a lifetime, some 60% of people will experience traumatic events. Acknowledging the painfulness of such events and the fact that some people develop problems such as PTSD, depression, and substance abuse, Meichenbaum notes that after trauma most people cope and many eventually experience *Post Traumatic Growth*: “Resilience is more accessible and available to some people than for others, but *everyone* can strengthen their resilience” (p. 5). This book identifies what those people do (and don’t do) and offers a *Resilience Reintegration Program* divided into six sections: 1. Physical Fitness, 2. Interpersonal Fitness, 3. Emotional Fitness, 4. Thinking (or Cognitive) Fitness, 5. Behavioral Fitness, and 6. Spiritual Fitness. Each section is multifaceted, offering specific actions to be taken, with useful information and inspiring Quotable Quotes to support each action. Some brief references are provided, and there are many website resources listed for the technologically savvy (start with www.roadmaptoresilience.org). The language is direct, pragmatic, encouraging, and down to earth. The actions are offered as suggestions and invitations, a compendium of specific “How To” ways to improve one’s resilience and fitness. They are as up-to-date as tomorrow’s sunrise: practical, optimistic, respectful, and sensitive to cultural nuance. There are “Hinge Questions” to help swing open the doors of possibility. The book also has brief appendices to help readers develop their personal resilience plan and to locate pages with specific steps (e.g., Control My Anger, Create a Healing Story, Create a Resilient Mindset, Use My Faith, Improve Conflict Management Skills, Stay Connected and Reintegrate).

The strategies, all supported by experience and research, are drawn from different theories and approaches. Consistent with Meichenbaum’s Constructive Narrative Perspective, which highlights meaning-making and telling “the rest of the story,” the sections on Thinking (or Cognitive) Fitness and Spiritual Fitness are especially rich. Although written as a self-help *Roadmap*, therapists (including Ericksonians) will find much here to use with their clients. Anyone who has suffered trauma or cares about someone who has, will want this book. I recommend it most enthusiastically!

BOOK ORDER INFORMATION

Meichenbaum, D. (2013). Roadmap to Resilience. Clearwater, FL: Institute Press
 (Price \$35 - if ordered directly from Dr. Meichenbaum)
(See www.roadmaptoresilience.org)

Meichenbaum, D. (2007). Treatment of Individuals with Anger-control problems and aggressive behaviors. Clearwater, FL: Institute Press
 (Price \$65 – if ordered directly from Dr. Meichenbaum)

Air Mail and Shipping and Handling Charges

Canada and Mexico --Add \$ 10 (Total Price \$ 45)

Rest of the World --Add \$ 15 (Total Price \$ 50)

**Send check made out to Don Meichenbaum
 Don Meichenbaum
 215 Sand Key Estates Drive
 Clearwater, FL 33767**

FUTURE TRAINING OPPORTUNITIES WITH DR. MEICHENBAUM : FIVE DAY WORKSHOPS

**July 21-25 , 2014 Door County , Wisconsin
 Core Tasks Of Psychotherapy: What "Expert" Psychotherapists Do**

**August 4- 8 , 2014 Cape Cod , MA.
 Core Tasks Of Psychotherapy: What "Expert" Psychotherapists Do**

**August 11-15, 2014 Cape Cod , MA.
 New Developments In The Treatment Of PTSD and Complex PTSD**

**(For a description of the Door County workshop see
 (<http://www.mcw.edu/psychiatry/doorcounty2014.htm>)**

(For a description of the Cape Cod workshops see www.neei.org)

ENCLOSED IN THIS FILE ARE HANDOUTS THAT ACCOMPANY EACH OF DR. MEICHENBAUM'S PRESENTATIONS. PLEASE SEND ANY FEEDBACK TO DR. MEICHENBAUM (dhmeich@aol.com)

I WORKSHOP 14 WED. DEC.11 2:30-5:30

**TREATMENT OF INDIVIDUALS WITH PTSD AND COMORBID DISORDERS: A
CONSTRUCTIVE NARRATIVE PERSPECTIVE**

In the aftermath of traumatic and victimizing experiences, some 75% of individuals will be impacted, but they go on to evidence resilience, and in some instances, to experience post traumatic growth. In contrast, some 25% will evidence persistent PTSD, related adjustment problems, and in 80% of cases, comorbid psychiatric disorders. PTSD is essentially a disorder of non-recovery.

In this workshop, Dr. Meichenbaum will:

1. discuss what distinguishes the 75% resilient individuals versus the 25% who evidence chronic distress and the implications for treatment;
2. will provide a Constructive Narrative Perspective of PTSD, highlighting the "stories" that individuals tell themselves, as well as others. PTSD is a reflection of a specific form of autobiographical memories;
3. evaluate the "state of the art" of treating individuals with PTSD and Complex PTSD. Critique the various forms of ACRONYM psychotherapies that are designed to treat individuals with PTSD and comorbid disorders;
4. consider the nature of resilience and the emerging research literature on the neurobiology of resilience and the treatment implications. He will consider ways to bolster resilience in six domains (physical, interpersonal, emotional, cognitive, behavioral, spiritual --see www.roadmaptoresilience.org);
5. discuss how to alter interventions for clients who evidence guilt, shame, anger, complicated grief and moral injuries;
6. examine ways to conduct integrative treatments for clients with comorbid psychiatric disorders such as PTSD and Substance abuse disorders. A CHECKLIST for evaluating Residential Treatment Center is included in the Handout.
7. examine ways to bolster resilience in "high risk" traumatized children;
8. consider ways to help the helpers so they evidence "vicarious resilience", as compared to "vicarious traumatization" (See the Melissa Institute website www.melissainstitute.org for a Handout by Meichenbaum on ways to help the helpers).

In this presentation, Dr. Meichenbaum will use video cases to illustrate ways to conduct a "strengths-based approach" to treat traumatized individuals.

**FOR A DISCUSSION OF THE ROLE OF THE THERAPEUTIC ALLIANCE IN
TREATMENT PTSD CLIENTS SEE THE CHAPTER ACCOMPANYING PANEL
DISCUSSION ON PTSD**

**TREATING INDIVIDUALS WITH PTSD, COMPLEX PTSD, and
COMORBID PSYCHIATRIC DISORDERS: LESSONS FROM
RESEARCH on RESILIENCE**

**Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo, Ontario,**

**Research Director,
Melissa Institute for Violence Prevention
Miami, Florida**

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CONTROVERSIES IN THE TREATMENT OF INDIVIDUALS WITH PTSD

1. Conceptualization of PTSD

- a. Issues concerning Criterion A. Non criterion A events can result in equivalent rates of PTSD. Can develop PTSD symptoms in absence of traumatic events. Question of causality.
- b. Issues of “Criterion-creep”- what constitutes a Criterion A event?
- c. Most individuals (70%+) do not develop PTSD and related adjustment difficulties. Rather they evidence **RESILIENCE**. Issues of natural recovery process and what gets in the way?
- d. Question Diagnostic Criteria A2- - involving fear, horror and helplessness. Evidence of other emotional reactions. Should PTSD be considered an Anxiety Disorder?
- e. Issue of symptom overlap and comorbidity. PTSD is an “amalgam” of other disorders. Difficult to discern what symptoms are unique to PTSD.
- f. Little evidence of delayed onset PTSD - - issue of subsyndromal reactions.
- g. No evidence of special mechanisms of traumatic memories, nor claims of “body memories”.
- h. Search for biological markers has not proven successful. Lack sensitivity and specificity to PTSD. Such biological markers may prove to be a vulnerability factor.
- i. Need for cultural/racial, gender and developmental factors in assessment and treatment.

2. Treatment Issues

- a. Equivalent Outcomes of Treatments for PTSD and Complex PTSD. (See Powers et al. 2010; Wampold et al. 2010). Dismantling studies fail to identify active ingredients DTE, CPT, PCS, EMDR, as examples).
- b. Consideration of **ACRONYM THERAPIES (PET, DTE, CPT, VRE, EMDR, CBT-ASD, SIT, AMT, ACT, CR, NET, KIDNET, TP, IRT, CP, DBT, IPT, TF-CBT, CBITS, PFA)**.
- c. Integrated Treatments for Patients with Comorbid Disorders (SS, TARGET, STAIR-MPE, DBT- - augmented for exposure).
- d. Target-specific Interventions (Sleep disturbance & nightmares, Dissociation, Guilt, Shame, Complicated Grief, Anger, Moral Injuries, Depression, Anxiety- - panic attacks, phobias, Substance Abuse Disorders).

- e. Spiritually-oriented Treatments and other treatment approaches
(Twelve Step AA programs, Smart-Recovery, Present-centered treatments, Culturally-based interventions like rituals- - Sweat Lodge activities, Psychodynamic therapies, Hypnosis, Supportive Group treatment, Inpatient treatment, Self-help Internet-based Treatment-Interapy, Community-based Interventions).
 - f. Pharmacotherapies- (See Friedman et al. 2009). Selective Serotonin Reuptake Inhibitors (SSRI's such as setraline, paroxetine and fluoxetine) and a Serotonin Norepinephrine Reuptake Inhibitor (SNRI such as venlafaxine extended release) have yielded limited positive results. About 30% have complete remission after 12 weeks of SSRI treatment, while half of those having a partial response achieve continual improvement with additional 24 week treatment. More successful in the reduction of positive than negative symptoms. However, discontinuation of SSRI's is often followed by relapse in those who show a initial and favourable response. "No magic bullet" for treatment of PTSD and Complex PTSD.
 - g. **Treatments to Avoid**
Debriefing Procedures such as CISM, Psychoeducational Interventions that can establish "negative" expectations and interfere with natural healing processes, "Energy-based" treatments such as Thought Field Therapy, Trauma Incident Resolution, Visual Kinesthetic Dissociation, Recovery-based Interventions, age regression, certain forms of grief counselling (See Wittouck et al. 2011).
3. **How to Spot "Hype" In Psychotherapy Presentation**
Presentation style; "Tricks of the trade" to oversell interventions; Check the nature of the Comparison Groups in Randomized Controlled Studies; Issues of Bonafide Treatments; Allegiance Effects; The "packaging" of interventions.
4. **Implications for the Treatment of Individuals with PTSD, Complicated PTSD and Comorbid Psychiatric Disorders.**
- a. What distinguishes those who develop chronic disorders versus those who evidence Resilience? Implications for treatment?
 - b. What are the common core competencies that cut across diverse interventions?
 - c. What barriers interfere with the Natural Recovery process and how can these be anticipated and addressed?
 - d. Critical role of a Case Conceptualization Model that informs ongoing assessment/evaluation and need for integrated treatment decision-making?
 - e. Need for culturally, racially, gender and developmentally-sensitive interventions.

“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Cognitive Level

Engage in self-focused, “mental defeating” type of thinking. Perception that one has lost autonomy as a human being, lost the will to exert control and maintain identity, lose the belief that one has a “free will”. See self as a “victim”, controlled by uninvited thoughts, feelings and circumstances, continually vulnerable, unlovable, undesirable, unworthy. Use dramatic metaphors that reinforce this style of thinking. “I am a prisoner of the past”, “Entrapped”, “Contaminated”, “Damaged goods”, “A doormat”, “A pariah”. Experience a form of mental exhaustion, mental weariness.

Hold erroneous beliefs that changes are permanent, the world is unsafe, unpredictable and that people are untrustworthy. Hold a negative, foreshortened view of the future and the belief that life has lost its meaning.

Engage in self-berating, self-condemnation, self-derogatory “story-telling” to oneself and to others (i.e., self blame, guilt-engendering hindsight, biased thinking; anger-engendering thoughts of viewing provocations as being done “on purpose”).

Engage in upward social comparisons, so one compares poorly in one’s coping abilities.

Be preoccupied with what others think of you. Engage in comparison of self versus others; before versus now; now versus what might have been.

Ruminate repeatedly, dwell on, focus upon, brood, pine over losses, “near miss” experiences.

Replay over and over your concerns about the causes, consequences and symptoms related to negative affect and losses. Use repetitive thinking cycles (“loss spiral”).

Engage in contra-factual thinking, repeatedly asking “Why me” and “Only if” questions for which there are no satisfactory answers.

Engage in avoidant thinking processes of deliberately suppressing thoughts, using distracting behaviors, using substances; avoidant coping behaviors and dissociation.

Have an overgeneralized memory and recall style which intensifies hopelessness and impairs problem-solving. Difficulty remembering specific positive experiences. Memories are fragmented, sensory driven and fail to integrate traumatic events into autobiographical memory or narrative.

Engage in “thinking traps”. For example, tunnel vision as evident in the failure to believe anything positive could result from trauma experience; confirmatory bias as evident in the failure to retrieve anything positive about one’s self-identity; or recall any positive coping memories of what one did to survive, or what one is still able to

accomplish “in spite of” victimization; do mind-reading, overgeneralizing, personalizing, jumping to conclusions, catastrophizing; “sweating the small stuff”, and emotional reasoning such as viewing failures and lapses as “end points”.

Evidence “stuckness” in one’s thinking processes and behavior. Respond to new situations in post-deployment settings “as if” one was still in combat (misperceive threats).

At the Emotional Level

Engage in emotional avoidance strategies (“Pine over losses”, deny or shift your feelings, Clam up, bury your emotions and do not consider the possible consequences of doing so).

Magnify and intensify your fears and anger.

Experience guilt (hindsight bias), shame, complicated grief, demoralization.

Fail to engage in grief work that honors and memorializes loved ones or buddies who were lost.

Fail to share or disclose feelings, process traumatic memories. Focus on “hot spots” and “stuck points”.

At the Behavioral Level

Engage in avoidant behaviors of trauma-related feelings, thoughts, reminders, activities and situations; dissociating behaviors.

Be continually hypervigilant, overestimating the likelihood and severity of danger. Act as if you are on “sentry duty” all the time; Act like a faulty smoke detector that goes off at the slightest signal.

Engage in safety behaviors that interfere with the disconfirmation of emotional beliefs and the processing (“restorying”) of trauma-related memories and beliefs.

Engage in delay seeking behaviors. Avoid seeking help. Keep secrets and “clam up”.

Engage in high risk-taking behaviors; chasing the “adrenaline rush” in an unsafe fashion; Put self at risk for revictimization.

Engage in health-compromising behaviors (smoking, substance abuse as a form of self-medication, lack of exercise, sleep disturbance that goes untreated, poor diet, dependence on energy drinks, abandonment of healthy behavioral routines).

Engagement in self-handicapping behaviors (“excuse-making”), avoidance behaviors.

Use passive, disengaged coping behaviors, social withdrawal, resigned acceptance, wishful thinking and emotional distancing.

At the Social Level

Withdraw, isolate oneself, detach from others.

Perceive yourself as being unwanted, a “burden”, thwarted belongingness, distrusting others. (“No one cares”, “No one understands”. “No one can be trusted”).

Associate with peers and family members who reinforce and support maladaptive behaviors. Put yourself in high-risk situations.

Experience an unsupportive and indifferent social environment (i.e., critical, intrusive, unsympathetic- - offering “moving on” statements).

Fail to seek social support or help, such as peer-related groups, chaplain services, or professional assistance.

At the Spiritual Level

Fail to use your faith or religion as a means of coping.

Have a “spiritual struggle” and view God as having punished and abandoned you.

Use negative spiritual coping responses. Relinquish actions to a higher power, plead for miracles, or divine intervention; Become angry with God; Be demanding.

Experience “moral injuries” that compromise values. Lose your “moral compass” and “shatterproof beliefs”, experience a “soul wound”.

Avoid contact with religious members who can be supportive.

PSYCHOLOGICAL CHARACTERISTICS OF RESILIENT INDIVIDUALS

Experience Positive Emotions and Regulate Strong Negative Emotions

Be realistically optimistic, hopeful, ability to laugh at oneself, humor, courage, face one's fears and manage emotions. Positive expectations about the future. Positive self-image. Build on existing strengths, talents and social supports.

Adapt a Task-Oriented Coping Style

Ability to match one's coping skills, namely direct action present-focused and emotionally-palliative acceptance with the demands of the situation. Actively seek help and garner social supports. Have a resilient role model, even a heroic figure who can act as a mentor. Have self-efficacy and a belief that one can control one's environment effectively. Self confidence. Seek out new and challenging experiences out of one's "comfort zone" and evidence "GRIT" or the perseverance and passion to pursue long-term goals.

Be Cognitively Flexible

Ability to reframe, redefine, restory, find benefits, engage in social problem-solving and alternative thinking to adaptively meet changing demands and handle transitional stressors.

Undertake a Meaning-Making Mission

Create meaning and a purpose in life; survivor's mission. Use one's faith, spirituality and values as a "moral compass". Be altruistic and make a "gift" of one's experience. Share one's story. General sense of trust in others.

Keep Fit and Safe

Exercise, follow a routine, reduce risks, avoid unsafe high-risk behaviors (substance abuse, chasing "adrenaline rush" activities).

HOW TO CREATE A “HEALING STORY”

*Every year of our lives, we add well over half a million minutes to our banks of experience. How we organize, chronicle, interpret, imbue them with meaning, share these experiences and weave them together into “stories”, will influence how **RESILIENT** we become.*

We don’t just tell stories, stories tell us. The tales we tell hold powerful sway over our memories, behaviors and even identities. Stories are fundamental to our being. Once you tell a story, it is hard to get out of that story’s framework. Over time, the stories we tell tend to get more dramatic. The stories we tell others and to ourselves grip our imagination, impregnate our hearts and animate our spirit.”

1. Following exposure to traumatic events, may evidence chronic distress, and even develop Post-traumatic Stress Disorder and related problems. For such disturbed individuals, their memories are over generalized (lacking in detail) that intensify hopelessness and impairs problem-solving. Their traumatic narrative is inadequately integrated into their autobiographical memories. Their stories have an inflated sense of responsibility with accompanying excessive guilt and shame. They misperceive their distressing reactions as signs that they are “going crazy” and that they are “worthless” and that they are a burden on others. Their stories convey the belief that the world is unsafe and unpredictable, unjust, and that people are unappreciative of their sacrifices, untrustworthy and unsympathetic. They may feel marginalized.

For those who are struggling, their stories are filled with “hot spots” and “stuck points” and their thoughts and accompanying feelings are viewed as unwanted, uninvited and involuntary, and poorly controlled, nor accepted.

In their attempt to stop or suppress such thoughts and feelings, and in their efforts to avoid reminders, they may paradoxically experience even more intrusive distressing thoughts, images and intense feelings and urges. Their coping efforts actually **BACKFIRE** and act like a **BOOMERANG**. They may try to cope by self-medicating (using alcohol, drugs), by trying distraction or engaging in high-risk behavior (withdrawing, isolating themselves, being hypervigilant, on “sentry duty” all the time) that inadvertently, unwittingly and perhaps, unknowingly make their level of distress even worse.

2. In contrast, **RESILIENT** individuals and Service Members are psychologically agile and flexible in how they tell their stories. They include in their story-telling examples of what they did and how they coped and survived. They tell the “rest of their story”. They weave into their story -telling the upside of what happened, as well.
3. Resilient individuals may take some time to experience grief or unhappiness, distress, anger and loss, sadness and anxiety which improves their abilities to better appreciate the world in all of its complexity and richness.

4. Resilient individuals tend to tell stories that have redemptive sequences in which bad events have good outcomes, as compared to contamination sequences when the reverse happens.
5. Resilient individuals slow down how they tell their stories and break their experiences into pieces. They examine the pieces in terms of all the complexities and then they connect the dots. They do not act like a “Monday morning quarterback,” who has hindsight bias, blaming themselves for things they did not know at the time.
6. Resilient individuals are on the lookout for unexplored “open spaces” in their narrative that act as a guide to new goals and alternatives. Redemption stories bolster hope, strengthen self-confidence that their efforts will bear fruit. They strengthen the belief in the possibility of positive outcomes. Changes in story-telling provide access to new solutions.
7. Resilient individuals tend to tell **COHERENT STORIES** that create meaning out of their stressful life experiences and in which they see themselves as “personal agents”, often with the assistance of others, of the positive changes that they have been able to bring about. These **COHERENT NARRATIVES** are clearly articulated, detailed, logical and well organized. Such **COHERENT** stories are salutary and help reduce distress. They increase the survivor’s sense of control over his or her experiences, reduces feelings of chaos and increases the sense that the world is predictable, orderly and beneficent. Coherent story-telling can provide a degree of “closure” by helping make sense of what happened and how people responded. Narrative coherence conveys a sense of personal self-efficacy and helps individuals make sense of what happened and points a direction to the future. It is not enough to help individuals create a trauma narrative, but it is also essential to help individuals integrate such thoughts and feelings into a consistent coherent meaningful experience and story. Trauma is only one part of an individual’s life, rather than the defining aspect.
8. Resilient individuals have the ability and penchant to tell their fragmented stories in a chronological narrative with a before, middle and post-trauma exposure or post-deployment parts. They are able to integrate what happened during deployment into their autobiographical memory and let the “past be the past”. As one Resilient individual stated: “I have no interest in going back to the past and getting stuck again”. Resilient individuals refuse to allow the “trauma stories and images” to become dominant in their narrative and take away their sense of identity. They can disentangle themselves from the influence and lingering impact of traumatic events. They engage in a narrative healing process.
9. Resilient individuals avoid “thinking traps” that can derail their story-telling (**See item 65**). Instead they incorporate in their story-telling “cherished recollections”, “fond memories”, a “heritage of remembrances”, “change talk”, (**See item 66**), “RE-verbs”, (**See item 62**). Resilient individuals tell stories that enrich their lives and help them get past their personal challenges. They tell stories that they can pass onto the next generation, as “lessons learned”.

10. Resilient individuals tell their stories first and then they live their way into them. They may act “as if” they are characters in the stories that they tell. There may be a certain amount of “fake it, until you make it.”

11. Listen to the stories you tell others and that you tell yourself. Do your stories include:

- a) **Redemptive (positive ending) sequences;**
- b) **RE-words and change talk action verbs;**
- c) **Goal statements and “how to” pathways thinking;**
- d) **Problem-solving strategies, Action Plan with “if...then” statements and expressions of self-confidence and “GRIT” (dogged persistence);**
- e) **Expressions of optimism, including statements of benefit finding and benefit remembering (“Silver lining” thinking), downward comparisons (“Could have been worse”) statements;**
- f) **Meaning-making statements (“Making a gift”, “Sharing lessons learned” statements)?**

Ask yourself and others, if the stories you tell are elaborate, organized, coherent (having a beginning, middle and end) that is now integrated as part of your autobiographical memory? Does your story open up new possibilities for change and provide a positive blueprint for the future?

**CORE TASKS OF PSYCHOTHERAPY:
WHAT “EXPERT” THERAPISTS DO BASED UPON
THERAPEUTIC PRINCIPLES OF CHANGE**

- a. Develop a collaborative **therapeutic relationship/alliance** and help the patient "tell" his/her story. After listening attentively and compassionately to the patient's distress and "emotional pain", help the patient identify "strengths" and signs of resilience. ***"What did he/she accomplish in spite of...?" "How was this achieved?"*** Obtain the "rest of the story". Use Socratic Questioning.
 1. Foster bonding between patient and therapist. Address any ruptures or strains in the alliance and address any therapy-interfering behaviors.
 2. Collaborate with the patient in establishing treatment goals and the means to achieve these goals.
 3. Encourage the patient's motivation to change and promote the patient's belief that therapy can help. (Use Motivational Interviewing Procedures).
 4. Monitor the patient's progress and use the information to guide ongoing treatment.

- b. Be **culturally-sensitive** when conducting assessments and the therapist should **develop treatment knowledge** and **competence** in treating ethnically diverse populations.
 - i. As Bowman (2007) highlights, ***"Become more aware of your existing assumptions, and accept that some of these assumptions may not apply to ethnic minority groups"*** (p. 113)
 - ii. Conduct an ethnocultural assessment that taps the patient's level of acculturation, circumstances and impact of migration on family and on self.
 - iii. Assess for culturally specific symptomatology and provide culturally-based interventions.
 - iv. Treatment should be sensitive to the patient's expectations, cultural interpersonal style, values and metaphors/language. Interian and Diaz-Martinez (2007) provide a good example of such cultural adaptation with Hispanic patients as they alter psychotherapy to include such Hispanic concepts such as Simpatico, Respeto, Formalismo (setting examples), Personalismo, Fatalismo, Marianismo (self-sacrifice), Poner de mi parte (doing one's part), Dichos (saying and proverbs) and religious values. (See Handout on Cultural Issues). When conducting these culturally-based interventions, it is important **not** to impose cultural stereotypes and recognize marked differences **within** cultural groups.
 - v. Tailor interventions to ethnic groups. For example, see Hinton et al., (2006) treatment of Cambodian refugees for treatment of panic attacks.
 - vi. Address any potential cultural barriers that might arise in treatment.

- vii. Be willing to consult with individuals who may be more equipped to deal with ethnic diversity and learn to conduct multicultural therapy.
- c. On an ongoing basis **educate** the patient about his/her problems and possible solutions and **facilitate awareness**. Use various ways to educate and nurture a sense of curiosity and discovery.
- Conduct Risk and Protective Factors assessment and provide constructive feedback. Probe about the patient's views of presenting problems and his/her theories of behavioral change.
 - Use a Case Conceptualization Model and share therapy rationale.
 - Have the patient engage in self-monitoring and conduct situational and developmental analyses.
 - Use videotape modeling films and other educational materials (simple handouts with Acronyms)
 - Use a "Clock metaphor" – "Vicious Cycle" Model

12 o'clock - external and internal triggers

3 o'clock - primary and secondary emotions

6 o'clock - automatic thoughts, thinking patterns and schemas or beliefs. Note common core recurrent patterns

9 o'clock - behaviors and resultant consequences

The therapist can use his/her hand to convey the Clock Metaphor by moving his/her hand slowly from 9 o'clock around to 6 o'clock. The therapist can say:

"It sounds like this is just a vicious...(without completing the sentence) allowing the patient to interject- - "cycle or circle". To which the therapist can then say, "In what way is this a vicious cycle? Are you suggesting...?"

The therapist can then help the patient come to appreciate how his/her appraisal of situations (12 o'clock), feelings (3 o'clock), thoughts (6 o'clock) and behaviors (9 o'clock) are all interconnected. The patient can be invited to "collect data" (self-monitor), if indeed, the "vicious cycle", as the patient describes it, actually occurs. In this way, the patient can bring into subsequent sessions data supporting the Clock Metaphor.

“If you (the patient) are engaging in such cyclical behaviors, then what is ‘the impact, what is the toll, what is the emotional and behavioral price that you are paying? Is that the way you want things to be? If not, then what can you do about it?’”

It is not a big step for the patient to suggest that one of the things he/she could do is “Break the cycle”. “Break the cycle. What did you have in mind?”, the therapist can ask. The therapist can now explore collaboratively with the patient how he/she can break the cycle. Moreover, the therapist can help the patient come to appreciate how he/she has already been trying to “break the cycle” (e.g., by engaging in avoidance behaviors, or being aggressive).

Another way to use the Clock Metaphor is to help the patient view his/her primary and secondary emotions (3 o’clock) as “commodities” that the patient does something with. The therapist can ask:

“What do you do with all those feelings (emotions)?”

The patient may respond that he/she “stuffs the feelings”, or “drinks them away”, and if he/she does that, then what is the impact, the toll, the price he/she and others pay? Is that the way he or she wants things to be? If not, then what can be done about it?”

Once again, the therapist can use the “art of Socratic questioning” as a way to help the patients generate possible coping solutions. There is a greater likelihood of patients engaging in behavior change efforts if they come up with the ideas and the accompanying reasons for engaging in such behaviors, than if the therapist merely offers suggestions and directives, acting as a “surrogate frontal lobe” for his/her patients.

Therapist models thinking: Ask the patient: “Do you ever find yourself, out there, in your day-to-day experience, asking yourself the kind of questions that we ask each other right here?”

- vii. Educate the patient about relapse prevention strategies.
- viii. There is a caveat that should be highlighted concerning the psychoeducation of patients. Devilly and his colleagues (2006) have noted that under some conditions providing information can undermine the recovery process and act as a self-fulfilling prophesy of despair. They note that in the work on Psychological Debriefing that provides individuals with information about potential trauma responses may have a paradoxical effect on depression and PTSD.

d. Help the patient **reconceptualize** his/her "problems" in a more **hopeful** fashion.

i. Do a life-review (*Use Time-lines*). Identify "strengths."

Timeline 1 – Birth to present. Note stressors and various treatments.

Timeline 2 – Birth to present. Note “**strengths**” and “*In spite of*” and use “**How**” and “**What**” questions. Note evidence of any strengths that may extend back in time to prior generations and what they did to “survive” and cope with stressors. Note signs of “cultural resilience”.

Timeline 3 – Present into future

Highlight: *How things are now and how would the patient like them to be in the future?*

The therapist can go on to ask:

“What can we do to help you achieve your goals of ...?”

What have you tried in the past to achieve your goals of...? What has worked? What has not worked, as evident by...?”

“If we worked together, and I hope we will, how would we know if you were making progress? What changes would someone else notice in your behaviors?”

“Let me ask one more question, if I might. Can you foresee or envision anything that might get in the way or act as a barrier or obstacle to your achieving...? What do you think could be done to anticipate and address such potential barriers?”

- ii. Use collaborative goal-setting (short-term, intermediate, long-term goals)
- iii. Use videotape coping modeling films
- iv. Use letter-writing, journaling
- v. Use group processes – open-ended groups
- vi. Use Alumni clubs of successful patients (coping models)
- vii. Use hope-engendering mentors

e. Ensure that the patient has intra- and interpersonal **coping skills**

1. Highlight the discrepancy between valued goals and current behavior and consequences and consider what can be done to close this gap.
2. Train and nurture specific skills to the point of mastery.
3. Build in generalization – do not merely “train and hope” for transfer

(Follow the specific steps of what you need to do to before, during and after training in order to increase the likelihood to achieve generalization and ensure maintenance. (See **Meichenbaum's Handbook on Anger Control, pp. 334-341.**)

4. Put the patient in a consultative mode. (The patient needs to explain, and/or demonstrate or teach skills learned).
- f. Encourage the patient to **perform "personal experiments"**
 - a) Solicit change talk, commitment statements, self-explanations and self-generated reasons for behavioral change.
 - b) Facilitate "corrective emotional experiences" (ala Alexander & French, 1946).
 - c) Involve significant others.
 - d) Ensure that the patient takes the "data" from his/her personal experiments as "evidence" to unfreeze his/her beliefs about self, the future and the world.
 - g. Ensure that the patient **takes credit** for change
 - i. Use attribution training -- use metacognitive statements ("notice," "catch," "interrupt," "game plan")
 - ii. Nurture a sense of mastery and efficacy ("*In spite of ... How ...?*") Use the language of "becoming" and of possibilities.
 - iii. Monitor the degree to which the patient ascribes personal agency for change. Note the number of unprompted examples of where the patient takes the therapist's voice with him/her, especially active transitive verbs.
 - iv. Help the patient change his/her personal narrative or the "stories" he/she tells oneself and others.
 - h. Conduct **relapse prevention** – follow treatment guidelines on how to conduct relapse prevention (See **Meichenbaum's Handbook on Anger Control , pp. 355-361.**)
 - i. Be sensitive to the patient's beliefs, behaviors and interpersonal conflicts that may block recovery.
 - ii. Consider the episodic nature of the patient's psychiatric disorders and any possible anniversary effects.
 - iii. Identify high-risk situations and develop coping strategies.
 - iv. Consider family and peers factors that can **both** undermine and support change. Consider the impact of a High Expressed Emotional Environment on the recovery process of the patient (criticism, intrusiveness).

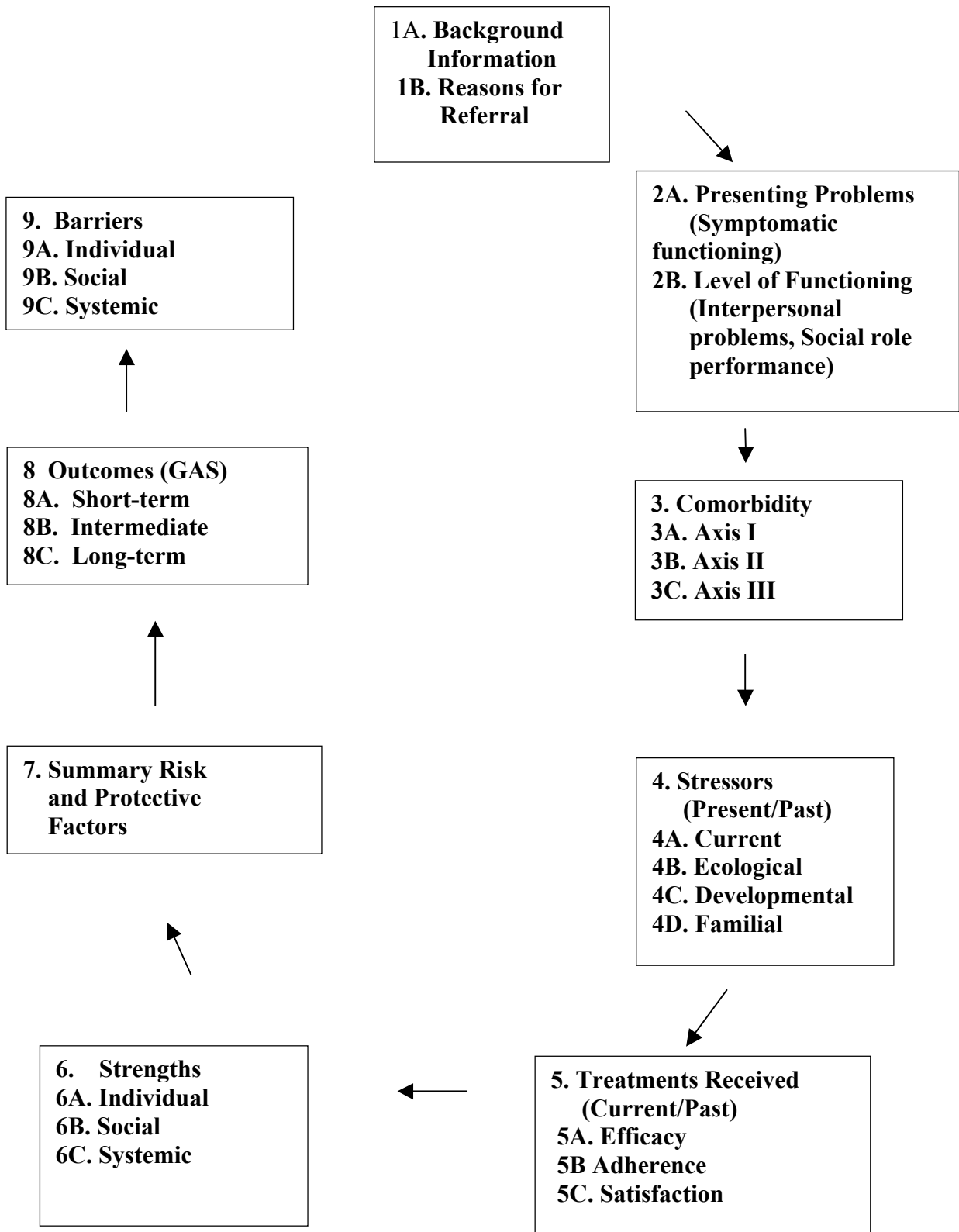
Additional Psychotherapeutic Tasks for Treating Psychiatric Patients With a History of Victimization.

(Note that approximately 50% of psychiatric patients have a history of victimization.)

- i. Address **basic needs** and **safety** and help the patient develop the tools for **symptom regulation** including treating symptoms of **comorbidity**
- Treat the patient for the sequelae of PTSD and Complex PTSD
 - Conduct an **integrated treatment** program, rather than sequential or parallel treatment programs
 - Normalize, validate and reframe symptoms as a means of coping and as a form of survival processes, “Stuckiness” issue
- j. Address **"memory work"** and help with the patient’s belief system
- Consider various forms of "retelling" trauma story -- A “restorying” process
 - Relive with cognitive restructuring: Contextualize memories --discriminate “then” and “now”, putting memories in the past
 - Consider what implications (beliefs) the patient has drawn as a result of victimization experiences (*“What lingers from ...”; “What conclusions do you draw about yourself and others as a result of ...”*)
 - Consider impact of "shattered assumptions" and how to rescript narrative. Listen for and use the patient’s use of metaphors
- k. Help the patient **find "meaning"**: Adopt a constructive narrative perspective
- Consider what the patient did to "survive"
 - What evidence of strengths in self and in others
 - What "lessons" learned that the patient can share with others – What can be salvaged from survivorship that the patient can make a “gift” to offer others?
 - What is the role of faith (spirituality)
- l. Help the patient **re-engage** and **"reconnect" with others**: Address the impact of trauma on family members, significant others and community.
- i. How to move beyond the "victim" role to that of becoming a “survivor”, even a “thrivers”
 - ii. How to engage in a proactive "helper" role
 - iii. How to connect with **adaptive/supportive** peers and community resources
- m. A major way individuals often cope with the aftermath of exposure to traumatic events is to use some form of **religion** or **spirituality**. There is a need for therapists to explore with patients for whom such spiritually-oriented coping procedures are central, various ways to integrate them into the psychotherapy process. In doing so, therapists need to be sensitive to cultural, developmental and gender differences.
1. Assess for the role of spirituality in coping process
 2. Where indicated, collaborate with local healers
 3. Work with local social organizations and social support systems

- n. **Help the helpers.** “Expert” psychotherapists monitor, assess and attend to the impact of vicarious traumatization.
- Interventions at the individual level
 - Interventions at the social or collegial level
 - Interventions at the level of the social agency
 - Work with local social outreach agencies
 - See www.melissainstitute.org for a discussion by Meichenbaum on ways to Reduce Vicarious Traumatization

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 is ...? (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)

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. “And some of the services you can access are...”

OVERVIEW OF TREATMENT

INITIAL PHASE I

- **Establish, maintain and monitor therapeutic alliance. Address therapy interfering behaviors and potential barriers.**
- **Ensure client safety: Ongoing Risk assessments and assess for comorbid disorders (Concurrent and sequential).**
- **Address immediate needs and provide assistance.**
- **Normalize and validate client’s experiences and tap his/her “implicit theories” of distress and change.**
- **Educate the client about presenting problems and about treatment. Use Case Conceptualization Model in the form of client and significant other feedback.**
- **Nurture Hope. Use Time Lines and related procedures.**
- **Collaboratively generate “SMART” treatment goals.**

PHASE II

- **Address target symptoms of PTSD and Complex PTSD (Dissociation, hyperarousal and avoidance behaviors, intrusive ideation, sleep disturbance, physical pain).**
- **Address comorbid-disorders in an integrated treatment fashion. (e.g., Substance Abuse Disorders, Anger-related problems, Identity and interpersonal challenges).**
- **Teach and nurture intra and interpersonal coping skills (Use Stress inoculation training procedures).**
- **Focus on Affect Regulation Skills (Emotional Regulation, Tolerance and Mindfulness Training)**
- **Bolster resilience-engendering behaviors**
- **Address treatment adherence issues (“Homework”, medication), Incorporate generalization guidelines such as Relapse prevention procedures.**

PHASE III

- **Address issues of traumatic memory and meaning-making.**
- **Use exposure-based interventions (Imaginal and in vivo).**

- **Use Cognitive Reconsideration and Cognitive-restructuring Rethinking activities (Attend to issues of guilt, shame, complicated grief, moral injuries).**
- **Help develop “Healing Stories”.**
- **Use spiritually-oriented interventions, where indicated. Help create “meaning-making” activities.**
- **Help the client develop and mobilize supportive relationships. Involve significant others. Nurture “connectedness”**

PHASE IV

- **Use client Checklists and nurture self-attribution processes.**
- **Re-visit Relapse Prevention procedures. Consider possible “anniversary effects”.**
- **Build in follow-up and follow-through procedures. Ensure continuity of care.**
- **Bolster Health Care Procedures’ Resilience: Help the Helpers (Individual, Collegial and Organizational supports).**

EXPOSURE-BASED TREATMENT FOR TRAUMATIZED CLIENTS *(Individually Tailor Intervention)*

Treatment Protocol

16- 20 90 minute sessions of repetitive recounting and revisiting. Process trauma by means of “restorying”.

- Develop the therapeutic alliance, conduct assessment and provide feedback. Determine role of other emotions besides anxiety (depression, guilt, shame, anger, complicated grief, moral injuries) and the presence of comorbid behaviors. Share treatment rationale and conduct psychoeducation (Use “clock” metaphor) (2 sessions).
- Cognitive therapy and relaxation training begin session 3.
- Imaginal exposure begins session 4.
- In vivo exposure begins around sessions 7 or 8.
- Relapse prevention and follow-through last two sessions.

Share Treatment Rationale

Validate and normalize individual’s reactions

Highlight “hope” for recovery

Discuss role of avoidance and safety behaviors in maintaining distress

Faulty “alarm system” (Smoke detector). “Wisdom of the body”. “Fight and flight response”. “Emotions (amygdala) hijacks thinking and behavioral processes”.

Treatment rationale for exposure-based interventions.

- Helps to process (“digest”) the trauma. Make sense of it. “File it in the correct file drawer in order to make sense of what happened.” Your mind keeps bringing the memory back, as if to digest it and fit it in”. “Take fragmented memories and ‘hot spots’ and embed them in a coherent memory bank”. Client has “choice” when to open file drawer.
- Habitation concept - - get used to it
Use examples of gradual exposure along a hierarchy
- Disconfirm belief that anxiety will persist forever. Appreciate that traumatic events are unique and relatively rare.
- Enhance sense of self-control, mastery, and competence.

- Address the client's fears about engaging in exposure activities. Realization that engaging in trauma memory does not result in "loss of control" or "going crazy."
- Involve significant others and family members in treatment and in exposure-based experiments.

Conducting Imaginal Exposure

Assist the client to:

- Recall the trauma vividly with eyes closed (open eyes if too distressed).
- Engage in the feelings elicited by the traumatic memories.
- Recount the events in the first person using the present tense.
- Include details of the events, including feelings and thoughts.
- Relive the trauma by listening to the audio taped narrative.
- Express empathy with the client's distress.
- Periodically reassure the client that he/she is "safe" and doing "fine".
- Allow sufficient time for calming after exposure.
- Solicit feedback from the client.

Conducting In-vivo Exposure

- Present treatment rationale and address any client concerns.
- Give examples of situational exposure ("Get back on the horse". "Beach examples").
- Develop a list of avoided situations.
- Rate the intensity of anxiety (SUD's) level - - Subjective Units of Distress, (0 to 100) and collaboratively arrange situations in a hierarchy.
- Begin with exposure that evokes a moderate level of anxiety (e.g., SUDs=50).
- Instruct the client to remain in each situation on the agreed upon hierarchy for at least 30 minutes or until anxiety decreases considerably (SUDs decrease by 50%).
- Fade use of safety behaviors as exposure progresses up the hierarchy.
- Build in self-attribution training ("taking credit" for behavior changes). Use meta-cognitive verbs and RE verbs.
- Conduct relapse prevention treatment.

RESILIENCE CHECKLIST

MY PERSONAL RESILIENCE PLAN

Creating A Vision of the Future

In each of the following **FITNESS** areas, identify the specific things you plan to do in order to improve your level of **RESILIENCE**. How much confidence do you have that you will be able to follow through on each Resilience Bolstering Behavior?

P - - PHYSICAL FITNESS

- _____ 1. Take care of my body.
- _____ 2. Exercise regularly.
- _____ 3. Get good sleep.
- _____ 4. Eat healthy.
- _____ 5. Avoid mood-altering drugs, overuse of alcohol.
- _____ 6. Manage pain (physical and emotional).
- _____ 7. Avoid high-risk dangerous behaviors.
- _____ 8. Other examples of ways I can **KEEP PHYSICALLY FIT**.

I - - INTERPERSONAL FITNESS

- _____ 9. Recognize deployment changes everyone and that readjustment takes time.
- _____ 10. Reconnect with social supports.
- _____ 11. Lean on others and seek and accept help.
- _____ 12. Give back and help others. Share my “islands of competence” with others.
- _____ 13. Participate in a social network.
- _____ 14. Share my emotions with someone I trust.
- _____ 15. Strike a balance between my war buddies and my loved ones.
- _____ 16. Overcome barriers to seeking help.
- _____ 17. Renegotiate my role at home.
- _____ 18. Use my communication (speaker/listener) skills and my social problem-solving skills.
- _____ 19. Use my cultural or ethnic traditions, rituals and identity as a support aide.
- _____ 20. Find a role model or mentor.
- _____ 21. Use community resources such as Websites, telephone hotlines.
- _____ 22. Be proud of the mission that I served with my “Band of Brothers/Sisters”.
- _____ 23. Use pets to maintain and develop relationships.
- _____ 24. Other examples of ways to **DEVELOP AND USE RELATIONSHIPS**.

E - - EMOTIONAL FITNESS

- _____ 25. Cultivate positive emotions (hobbies and pleasurable activities).
- _____ 26. Engage in an **UPWARD SPIRAL** of my positive emotions, thoughts and behaviors.
- _____ 27. Make a “**BUCKET LIST**” of emotional uplifting activities and then **JUST DO IT!**

- _____ 28. Show “**GRIT**” - - ability to pursue with determination long-term goals. (“Choose hard right, over easy wrong”).
- _____ 29. Use positive humor.
- _____ 30. Cope with intense emotions by using opposite actions.
- _____ 31. Give myself permission to experience and share emotions (feel sad, cry, grieve, become angry).
- _____ 32. Face my fears.
- _____ 33. Engage in constructive grieving (memorialize and honor those who have been lost).
- _____ 34. Share my story and the “rest of my story” of what led me to survive (share lessons learned).
- _____ 35. Allow myself to share my “emotional pain” with someone I trust.
- _____ 36. Journal - - use “writing cure”.
- _____ 37. Use creative expressive techniques (art, music) to process my feelings.
- _____ 38. Enjoy the benefits of self-disclosure.
- _____ 39. **RE**STORY my life and share evidence of my **RESILIENCE**.
- _____ 40. Take specific steps to **EMOTIONAL FITNESS**.
- _____ 41. Change my self-talk.
- _____ 42. Engage in non-negative thinking and become more **STRESS-HARDY**.
- _____ 43. Show gratitude.
- _____ 44. Other examples to improve my **EMOTIONAL FITNESS**.

T - - THINKING FITNESS

- _____ 45. Be psychologically flexible.
- _____ 46. Use constructive thinking and consider alternative solutions/pathways.
- _____ 47. Look at things differently.
- _____ 48. Establish achievable goals.
- _____ 49. Establish realistic expectations.
- _____ 50. Nurture hope.
- _____ 51. Be realistically optimistic.
- _____ 52. Have self- confidence and self-efficacy.
- _____ 53. Engage in benefit-finding. (Search for the silver lining).
- _____ 54. Engage in benefit-remembering.
- _____ 55. Engage in downward comparison. (Consider those less fortunate).
- _____ 56. Go on a meaning making mission. List and share positive military experiences with others.
- _____ 57. Engage in altruistic (helping) behaviors.
- _____ 58. Find meaning in my suffering and move toward “post-traumatic growth”.
- _____ 59. Consider lessons learned from my deployment.
- _____ 60. Be mindful- - stay in the present.
- _____ 61. Maintain my “moral compass”. Stick to my key values.
- _____ 62. Be careful of the “stories” I tell myself and others. Use “RE” verbs in my story-telling.
- _____ 63. Change the messages that I send to my brain.
- _____ 64. Avoid “**THINKING TRAPS**”. (*See list of what to avoid*).
- _____ 65. Nurture a positive view of myself, others and the future.

- _____ 66. Celebrate small triumphs
- _____ 67. Other examples of ways to improve my **THINKING FITNESS**.

B- BEHAVIORAL FITNESS

- _____ 68. Develop safe regular routines.
- _____ 69. Stay calm under pressure. Keep my cool.
- _____ 70. Prepare for possible high-risk situations.
- _____ 71. Break tasks into doable subtasks.
- _____ 72. Get unstuck from the past.
- _____ 73. Improve my “people-picking” skills. Avoid people, places and things that get me into trouble.
- _____ 74. Take a “news holiday”.
- _____ 75. Co-exist with my difficult memories and use positive emotions to UNDO negative memories.
- _____ 76. Self-disclose to a trusted person.
- _____ 77. Join a social group that gives my life a sense of purpose..
- _____ 78. Renegotiate my role and responsibilities.
- _____ 79. Adopt a **CAN DO** attitude.
- _____ 80. Read to find comfort.
- _____ 81. Gather information (visit websites).
- _____ 82. Avoid making things “worse”.
- _____ 83. Continue my “journey of healing” and view setbacks as “learning opportunities”.
- _____ 84. Use my **ACTION PLANS and BACK-UP PLANS**.
- _____ 85. Other examples of ways to improve my **BEHAVIORAL FITNESS**.

S- SPIRITUAL FITNESS

- _____ 86. Use **POSITIVE** religious/spiritual ways of coping.
- _____ 87. Avoid using **NEGATIVE** religious/spiritual ways of coping.
- _____ 88. Maintain **HOPE**.
- _____ 89. Visit the Chaplain or some other clergy person for assistance.
- _____ 90. Use some form of spiritual/religious/devotional activities.
- _____ 91. Participate in spiritual and religious groups.
- _____ 92. Engage in spiritual/religious rituals.
- _____ 93. Engage in commemorative services.
- _____ 94. Forgive others and also forgive myself.
- _____ 95. Use my religious beliefs as a coping tool. Create a Spiritual Family Tree. Write my Epitaph of what I want to be remembered for.
- _____ 96. Share the spiritual lessons learned from my deployment.
- _____ 97. Reset my “moral compass” and refocus on my core values and attributes that I brought home from my deployment.
- _____ 98. Walk away from **HATE** and the desire for **REVENGE**.
- _____ 99. Make amends with those who I have hurt.
- _____ 100. Recognize that life is short and make the most of every moment.
- _____ 101. Other examples of ways to improve my **SPIRITUAL FITNESS**.

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**THE EMERGING NEUROBIOLOGY of RESILIENCE:
IMPLICATIONS for PSYCHOTHERAPEUTIC INTERVENTIONS**

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Neurobiological Substrates of Resilience

1. Concept of Allostasis and Resilience – “Resilience is the capacity to minimize allostatic load”.
2. Chronic exposure to stressors and accompanying chronic negativity taxes the body. Impact of attentional bias.
3. Neurophysiological developmental consequences. Adverse Childhood Experiences Studies.
4. Genetic vulnerability factors- - comorbidity depression and substance abuse (see Caspi et al. 2003, Ray, 2012).
5. Impact on Hypothalamic-Pituitary – Adrenal Axis (HPA) and on the Immune System.
6. Factors Promoting Resilience
 - a) Protective capacity of positivity (buffer negative feelings).
 - b) Emotion regulation skills - - role of the prefrontal cortex and relationship to the amygdala (subcortical processes).
 - c) Social supports (“mirror neurons”).
 - d) Meaning-making and give-back activities.
7. The experience of positive-balanced emotions such as joy, pride, contentment, compassion and love have been associated with distinct neurobiological and physiological changes including increased activity in regions of the left prefrontal cortex, increased neurotransmission in mesolimbic dopaminergic pathways, attenuated startle response and increased cardiac vagal tone (Carl et al. 2013). Use Functional Magnetic Resonance Imaging (fMRI) to measure regional neural activity and functional connectivity during positive emotion regulation tasks.
8. Positive emotion regulation involves more left-lateralized activity in the prefrontal cortex (PFC); whereas regulation of negative emotions is associated with bilateral or right-lateralized activity in the PFC. Positive emotion regulation entails modulation of common emotion processing regions such as the amygdala, and reward processing regions such as ventral striatum (Kim & Humann, 2007).

9. Intervention Strategies To Bolster Resilience - - See Roadmap To Resilience
(www.roadmaptoresilience.org)

a) Keep physically fit: Role of exercise, diet and avoidance of risk behaviors

b) Keep interpersonally fit

Participate in positive activities

Situational selection - - choose settings

Situational modification - - alter the situation

Self-presentation - - smiling, dressing up

Communication strategies

Engage in acts of kindness

Gratitude activities

Access social networks and

c) Keep cognitively and emotionally fit

Goal setting and affective forecasting nurtures hope.

Attentional deployment in cognitive bias “threats” versus focusing on positive emotions.

Savoring and positive rumination present, past (reminiscing) and the future (anticipating). Positive events versus “dampening” or minimizing or eliminating positive events

“I don’t deserve this.” “This won’t last.”

Mindfulness activities - - pay attention in a particular way, on purpose in the present moment and nonjudgementally.

Loving-kindness meditation

Forgiveness activities for self and others

d) Keep spiritually fit

Use positive versus negative coping strategies

Use well-being therapy ala Fava and Ruini (2003).

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CONSUMER'S GUIDELINES FOR CHOOSING A RESIDENTIAL TREATMENT CENTER (RTC)

Donald Meichenbaum Ph.D.

For the last 20 years, I have been a consultant to various Residential Treatment Centers (RTCs) for clients who experience co-occurring disorders of substance abuse and various psychiatric disorders. I have trained staff on ways to develop integrative treatment programs that are designed to bolster the client's level of resilience (*see www.roadmaptoresilience.org*). In this consulting capacity, I have also helped them critically evaluate their programs to determine if they were meeting a "gold-standard" of care. My relatives, friends and colleagues know of my consulting work with these RTCs and they have, on occasion, asked me " How can I choose a Residential Treatment for my loved one or client?" I have written a letter that they can submit to the Director of RTCs in order to make a more informed decision about possible placement. Imagine what the impact might be if the Directors of RTCs had to address each of these questions on a regular basis or post the answers to these questions on their Website?

To: Director of Treatment

From: A Concerned Parent (Spouse Referring Therapist)

I am considering your Treatment Center for my family member. Before I decide on a placement, I would greatly appreciate your providing me with answers to the following questions so I can make an informed decision.

I gather that critical reviews of the treatment research literature indicate that the following factors have been found to be key predictors of outcome for clients with psychiatric and substance abuse disorders. They include:

- a) the quality of the therapeutic alliance that is established and maintained between clients and treatment staff;
- b) the degree of client engagement and active participation in treatment;

- c) the client's perception of improvement in training;
- d) the inclusion of an active aftercare program that involves significant others (family members), supportive non-substance abusing peers and the development of a long-term Recovery Program;
- e) the flexible implementation of a treatment package that incorporates regular feedback from outcome-driven results.

I would like to learn how your Treatment Center incorporates each of these treatment features. More specifically in terms of **Therapeutic Alliance**.

- (1) How does your treatment program develop and monitor a therapeutic alliance with clients? How does your staff handle possible impasses or strains that may arise over the course of treatment?
- (2) What specific client feedback measures about the quality of the therapeutic alliance does your staff regularly employ? For example, what specific Helping-alliance scales, client engagement/participation measures do you regularly obtain?
- (3) Since continuity of care is so important, please share your staff turnover data and what you have done to address this issue?
- (4) Since client engagement and active participation are critical to treatment outcome, what specific engagement strategies does your treatment center employ?
 - a) Is your staff trained and certified in using Motivational Interviewing procedures?
 - b) How does your staff engage clients in collaborative goal-setting and in developing a long-term Recovery Plan? (Could you please send me a copy of the Resident Handbook and of the Goal Sheets and Recovery Plan forms that clients are asked to fill out).
- (5) What is your Treatment Center's policy for involving family members (significant others) from the outset and keeping them informed throughout treatment?) Policy toward visiting, phone call consultations, family therapy and the like.

In terms of **Assessment Issues**, I would appreciate your addressing the following questions.

- (6) How effective has your Treatment Program been in helping clients become abstinent, or at least reducing their substance intake, and in developing a better quality of life? Please share what long-term outcome data you have collected (beyond testimonials). How do you go about collecting such follow up data on a regular basis?

- (7) How do you intend to obtain long-term data from clients and from significant others. I would appreciate any reports on your treatment efficacy.
- (8) I gather that the best assessment data in helping clients is to use ongoing outcome-driven feedback that is given to both clients and therapists in real-time. In this way both clients and therapists can adapt the treatment program in a flexible individualized fashion in order to reach agreed upon treatment goals. How does your treatment staff obtain such outcome-driven data and employ it in treatment? What specific assessment measures do your therapists employ and how is this information shared with all staff and the clients?
- (9) How does your treatment team assess for the presence and history of polysubstance use, comorbid disorders, risk to self and others? How is this information incorporated into an integrated Case Conceptualization Model that informs treatment decision-making?
- (10) How does your treatment staff assess for the “rest of the story”, namely, the client’s strengths, evidence of resilience, values, interests, talents, and how are these incorporated into the treatment plan? How does your staff explicitly nurture hope in clients, significant others, and staff?
- (11) How does your staff employ a life-span perspective and assess for early victimization and trauma exposure? If such developmental events are identified, how do you incorporate this into the client’s treatment program? What specific trauma-focused interventions do you use and how do you integrate them with the treatment of substance abuse?

In terms of **treatment issues** I would appreciate your addressing the following questions.

- (12) What is the weekly treatment schedule? Please indicate how each of these various activities have some evidence-based or empirical support for clients with comorbid disorders? How will engaging in these activities help with long-term recovery? Any evidence for this?
- (13) How does your staff provide integrative (as compared to sequential or parallel) treatment approaches for clients with dual diagnosis? Has your treatment team adapted and been trained in any specific evidence-based integrative treatment procedures? Which programs?
- (14) How do you ensure that your treatment staff communicate regularly and convey a similar treatment message to clients and significant others?
- (15) Most importantly, when your treatment staff train clients on a variety of intrapersonal and interpersonal coping skills, how do you ensure that the staff has incorporated generalization guidelines designed to improve the likelihood of transfer and maintenance of the treatment effects? In short, what explicitly does your staff do besides “train and hope” for generalization and maintenance of treatment effects?

- (16) What specific coping skills does your treatment team teach? How do you go about deciding which skills should be taught and nurtured (“tailored”) with which clients?
- (17) When psychotherapies are provided, either individual, group or family, what specific approaches are used? Is this left up to the individual psychotherapist or is there one general psychotherapy approach at your Treatment Center? What is the psychotherapeutic approach and how do you evaluate its effectiveness?
- (18) Given the high incidence of lapses and relapses, how does your treatment team incorporate relapse prevention training? How do you work with clients to develop and maintain a life of sobriety, a balanced life-style and a high quality of life that is drug free?
- (19) How are your various treatment interventions culturally and gender sensitive? How do you incorporate the client’s cultural background, rituals and values into treatment? Do you conduct any gender-specific treatment programs? Please describe them.
- (20) How do you incorporate spiritually-based interventions, such as 12 Step AA programs into your treatment program? How do you explicitly facilitate such AA programs in order to increase the likelihood that client’s will continue his or her participation, once he/she leaves the Treatment Center? Are such AA meetings on campus or off campus? How do you monitor the quality of these meetings? What percentage of the week’s activities are devoted to AA meetings?
- (21) How do you incorporate psychotropic medications as part of your treatment program? How do you go about educating clients about their medication, systematically assess for possible side-effects and efficacy, and ensure that the client “takes credit” (makes self-attributions) about what the medication has allowed him/her to achieve in terms of their treatment goals?
Since I raised the issue of medication, what is your Treatment Center’s policy about smoking and how do you handle clients who feel addicted to cigarettes?
- (22) How does your treatment program conduct an assertive after-care program with follow up, as well as contact with recovery programs in the client’s natural environment? What specifically, do you do in the form of follow-up contracts, assessments and ongoing contacts? Moreover, are there any additional charges for such aftercare activities, or is this service included in the initial treatment fees?
- (23) How do you explicitly address the needs of your staff at the individual, collegial and organizational levels in order to avoid burnout, vicarious traumatization and to ensure their professional development?

I realize that this is a long list of comprehensive questions, but I am sure you will understand my desire to make the best, most informed decision concerning our loved one. If you were in my shoes, I am certain you would want to thoughtfully address each of these areas of therapeutic

alliance, assessment procedures, treatment effectiveness, and various features of the treatment program in order to make an informed decision.

Thank you for your careful consideration of each of these questions, and I look forward to meeting you and discussing a possible placement at your setting.

WAYS TO BOLSTER RESILIENCE IN “HIGH RISK” CHILDREN

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ILLUSTRATIVE ADVERSITIES THAT CHILDREN AND FAMILIES EXPERIENCE IN THE U.S.

(See Fraser, 2004; Schorr, 1998; Smith & Carlson, 1997).

The following epidemiological data underscores the widespread occurrence that characterize “high risk” children and families. Such risk factors often pile up and the resultant problems tend to snowball. In spite of such cumulative exposure to such stressors, **1/2 to 2/3 of “high risk” children will grow up and “overcome the odds”**.

There are important gender differences in responsiveness to risk factors. Boys are more vulnerable than girls in childhood to the effects of biological insult, caregiving deficits and economic hardships. This trend is reversed in the second decade with girls becoming more vulnerable than boys in adolescence.

Children Who Are Maltreated

- ❖ There are approximately 2 million cases of child maltreatment (physical abuse and neglect) each year in the U.S.
- ❖ It is estimated that 20 million children live in households with an addicted caregiver and of these approximately 675,000 children are suspected of being abused

Children Who Witness Domestic Violence

- ❖ 3.3 million children witness assaults against their mothers annually. For example, in California, estimates that 10% - 20% of all family homicides are witnessed by children.
- ❖ 40% of men who abuse their female partner also abuse their children

Children as Victims of Crime

- ❖ Children are more prone to be subject of victimization than are adults. For example, the rates of assault, rape and robbery against those 12 to 19 years of age are two to three times higher than for the adult population as a whole.
- ❖ “Virtually all” of the inner ethnic minority children who live in the South Central Los Angeles witness a homicide by age 5. In New Orleans, 90% of fifth grade children witness violence. 50% are victims of some form of violence, and 40% have seen a dead body.
- ❖ 30% of children living in medium to high crime neighborhoods have witnessed a shooting, 35% have seen a stabbing and 24% have seen someone murdered (Osofsky, 1997).

Children Who Are the Offsprings of Mentally Ill Parents

- ❖ Children of clinically depressed mothers evidence behavioral and emotional difficulties. They also manifest neurological asymmetries.
- ❖ Children of antisocial aggressive parents evidence a higher incidence of aggressive behaviors and school failures.

Children Living in Poverty

- ❖ 25% of children (some 15 million students) in the U.S. live below the poverty line.
- ❖ The poverty level of the family is correlated with the level of the child achieving academically. Consider the following illustrative findings.
 - a) Students from minority families who live in poverty are 3x more likely than their Caucasian counterparts to be placed in a class for the educably delayed, 3x more likely to be suspended and expelled.
 - b) The overall academic proficiency level of an average 17 year old attending school in a poor urban setting is equivalent to that of a typical 13 year old who attends school in an affluent school area.
 - c) Students from families with income below the poverty level are nearly twice as likely to be held back a grade.
 - d) The dropout rate from school is highly correlated with grade retention. On average, two children in every classroom of 30 students are retained annually in the U.S.

- e) The school dropout rate for African American students in the U.S. is 39% and for Mexican American students the dropout rate is 40%.

These statistics take on specific urgency when we consider that 15% of American students are African American and 11% are Hispanic. If present birthrates continue, by the year 2020, minority students will constitute 45% of school-age students in the U.S., up from the current level of 30%. While any one of these factors such as living in poverty, experiencing abuse and neglect, or witnessing violence or being a victim of violence constitute high risk for poor adjustment, research indicates that it is **the total number of risk factors, present that is more important than the specificity of the risk factors in influencing developmental outcomes**. Risk factors often co-occur and pile up over-time.

The cumulative impact of exposure to varied stressors is illustrated by the research by Valerie Edwards and their group at the University of Texas (2005). They developed an interview/questionnaire that assesses the child's exposure to negative Adverse Childhood Experiences, ACE (See Table of ACE categories). They found that the higher the scores on the ACE, the greater the likelihood of poorer developmental outcomes, as evident in both psychosocial and physiological indices. No child is invulnerable. There are situations where no child could flourish.

TABLE 1
ADVERSE CHILDHOOD EXPERIENCES
(ACE QUESTIONS AND RESPONSE CATEGORIES)*

ACE Category	Question(s)	Response Options	Criterion for Category
Physical Abuse: Did a parent or other adult in the household;	Push, grab, shove or slap you? Hit you so hard that you had marks or were injured?	Never, once or twice, sometimes, often, very often.	Often and/or Sometimes
Psychological Abuse: Did a parent or other adult in the household;	Swear at, insult, or put you down? Act in a way that made you afraid you would be physically hurt? Threaten to hit you or throw something at you but didn't?	Never, once or twice, sometimes, often, very often.	Often Often Often
Sexual Abuse: Did an adult 5 years older than you:	Touch or fondle you in a sexual way? Have you touched his/her body in a sexual way? Attempt intercourse (oral, vaginal, or anal) with you? Have intercourse (oral vaginal, or anal) with you?	Yes/No	Yes to any question
Witnessing Maternal Battering: Did your father or stepfather or mother's boyfriend ever:	Push, grab, slap or throw something at your mother or stepmother? Kick, bite, hit her with a fist or something hard? Repeatedly hit her over at least a few minutes? Threaten or hurt her with a knife or gin?	Never, once or twice, sometimes, often, very often.	Often and/or Sometimes Once or twice Once or twice
Household Mental Illness: Was/did someone in your household:	Depressed or mentally ill? Attempt suicide?	Yes/No	Yes
Household Substance Abuse: Was someone in your household:	A problem drinker or alcoholic? A person who used street drugs?	Yes/No	Yes
Household Criminal Activity:	Did a household member ever go to prison?	Yes/No	Yes
Parental Divorce or Separation:	Were your parents ever divorced or separated?	Yes/No	Yes

*Edwards, V. J., Anda, R. F., Dube, S. R., Dong, M., Chapman, D. P., & Felitti, V. J. (2005). The wide-ranging health outcomes of adverse childhood experiences. In K. A. Kendall-Tackett and S. M. Giacomoni (Eds.), *Child victimization*. Kingston, NJ: Civic Research Institute.

CONSIDERATION OF THE PHYSIOLOGICAL AND PSYCHOLOGICAL CONSEQUENCES OF SUCH “VICTIMIZATION” EXPERIENCES: IMPLICATIONS FOR BOLSTERING RESILIENCE

- ❖ **Neuropsychological Sequelae (Consequences)**
- ❖ **Emotional and Social (Attachment) Sequelae**
- ❖ **Academic Consequences** – The role for providing “cognitive prosthetic devices” – delayed language, memory deficits, metacognitive deficits

NURTURING PROTECTIVE FACTORS: SOME THINGS TO KEEP IN MIND

- ❖ Resilience can be promoted, but cumulative risks call for cumulative protection. A chain of protective factors.
- ❖ There is no such thing as a single set of protective factors. Interventions should aggregate protective factors. No “magic bullet” solutions.
- ❖ Single-factor-focused interventions are not likely to affect more than a small part of the problem or a small portion of the children. Intervention strategies that target multiple risk and resources, processes and contexts are likely to have more impact.
- ❖ Interventions need to be developmentally and culturally sensitive.
- ❖ Interventions need to be ecologically valid (meaningful to group). “One size fits all” programs are not likely to be optimal. Interventions need to be multifaceted.
- ❖ Keep in mind Ann Masten’s observation that resilience does not require something rare and extraordinary. Children who “make it” against the odds have more resources in their minds, bodies, families and communities. These factors include:
 - Attachment relationships and social supports
 - A human brain in good working order
 - Opportunities to learn and experience effectiveness
 - Self-efficacy (“I can do it” motivation)
 - Regulation of emotional, arousal, behavior
 - A sense of belonging or meaning in life

- ❖ When “high risk” children were asked, as adults, who helped them “succeed against the odds”, the resilient children overwhelmingly and exclusively gave credit to:

“members of their extended family (grandparents, siblings, aunts and uncles), to neighbors and teachers who were confidants and role models and to mentors, in voluntary associations, such as 4-H, the Y and church groups.” Support from “ordinary” members of the community was more often sought and more highly valued than professionals.” (Werner & Johnson, 1999, p. 223).

(Also see Lefkowitz, 1987; McLaughlin et al., 1994; Miller, 1990; Polakow, 1993).

- ❖ Parenthetically, Werner and Johnson (1999) observe that resilience can also exact a “price”. For example, in order to develop into competent, confident and caring adults, some individuals had to detach themselves from family members.
- ❖ Consider the Lessons Learned from Interventions (*see www.teachsafeschools.org*)
- ❖ Don’t Oversell Protective Intervention Programs: Critically Evaluate Efforts (See Glantz & Johnson, 1999)

PROTECTIVE FACTORS FOR BOLSTERING RESILIENCE IN CHILDREN AND YOUTH

(Martin & Coatsworth, 1998; Masten & Reed, 2000; Meltzer et al., 2005)

Within the Child

- ❖ Easy-going disposition and positive temperament; not easily upset
- ❖ Good cognitive abilities, higher IQ, reading competence, problem-solving skills and attentional skills
- ❖ Positive self-perceptions, self efficacy, healthy expectations and goal-attaining skills
- ❖ Good self-esteem – an internal sense of worth and competence. Internal locus of control and sense of mastery.
- ❖ A positive outlook on life; an achievement orientation with high expectations
- ❖ Good self-regulation of emotional arousal and impulses
- ❖ Talents valued by self and society; bicultural competence
- ❖ Good sense of humor
- ❖ General appealingness or social attractiveness to others. Ability to elicit positive responses from others.
- ❖ High level of positive activities; high rate of engagement in productive activities
- ❖ Religious affiliations and a strong religious belief – cultural resilience
- ❖ Faith and a sense of meaning in life (spirituality)

Within the Family

- ❖ A close sustained relationship with at least one caring prosocial and supportive adult who is a positive role model

The best documented asset of resilience is a strong bond to a competent and caring adult, which need not be a parent. For children who do not have such an adult involved in their life, it is the first order of business ... Children also need opportunities to experience success at all ages (Masten & Reed, 2002).

- ❖ Connection to at least one competent and caring parent or caregiver – perception of availability and responsiveness of caregivers; strong support systems
- ❖ Authoritative parents who are high on warmth and support, but who also provide structure (set firm limits and state clear rules), monitor their child's behavior and peer contacts, and who convey high expectations in multiple domains. Ordinary parents – perfection not required.
- ❖ Positive family climate with low family discord between parents and between parents and children
- ❖ Organized home environment (role of rituals, ceremonies and mutual responsibilities, cohesive and supportive)
- ❖ A secure emotional base whereby the child feels a sense of belonging and security; access to consistent, warm caregiving
- ❖ Parents involved in their child's education. Both parents and teachers should convey high, but realistic expectations to their children.
- ❖ Socioeconomic advantages (Poverty is associated with an array of problems including low birthweight, infant mortality, contagious diseases, and childhood injury and death. Poor children are at risk for developmental delays in intellectual and school achievement.)

Within Other Relationships: Extrafamilial Factors

- ❖ Close supportive relationship with prosocial and supportive adult models (role of mentors). Bond to prosocial adults outside family.
- ❖ Connections to prosocial and rule-abiding prosocial peers and organizations; civic engagement
- ❖ Support from “kith and kin” Access to wider supports such as extended family and friends

Within the Community

- ❖ Effective communities
- ❖ Neighborhoods with high “collective efficacy”, social cohesion and social capital resources.
- ❖ High levels of public safety.
- ❖ Good emergency social services (e.g., 911 or crisis services, nursery school services)
- ❖ Good public health and health care availability
- ❖ Opportunities to learn and develop talents
- ❖ Support for cultural and religious traditions and respectful of diversities
- ❖ Have extended families who nurture a sense of meaning and identity (connected to larger community as evident in religious, cultural, community ties)

Within the School

- ❖ Create an Inviting Learning Environment of Safety and Support
 - a) Involve students in decision-making (curriculum, program planning, classroom and school rules)
 - b) Ask questions that encourage critical reflective thinking
 - c) Employ teaching approaches like co-operative learning, peer helping or cross-age mentoring
 - d) Use “authentic education” that engages and challenges students

- ❖ Attendance in effective schools and bonded to school; for instance ask students the following question to assess school-bondedness.

If you were absent from school, besides your friends, who else would notice that you were missing and would miss you?

- ❖ Increase the likelihood of academic success (See Model of Mastery, parent involvement, peer teaching procedures)
- ❖ Effective schools which are a manageable size that nurtures connectedness
- ❖ Engage with others (classmates, family and community members) in empowering activities such as helping others. For instance, a survey of some 1800 school principals by the National Youth Leadership Council found that schools that use “**service learning**” (some 28% of all school principals surveyed) evidenced a wide range of benefits for the students, school and community) (*See <http://www.nylc.org>*)
- ❖ Ties to prosocial organizations, including, schools, clubs, scouting. Participate in extracurricular activities.

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WEBSITE LINKS

American Psychological Association Resilience Project

<http://www.apahelpcenter.org/featuredtopics/feature.php?id=6>

www.apahelpcenter.org (1-800-964-2000)

University of Oregon Resilience Project

<http://orp.uoregon.edu/index.htm>

Describes 12 lessons (45-50 minutes each) designed to be used in small groups or classrooms with students in grades 4-8 (Strong Kids) and 9-12 (Strong Teens).

The Search Institute: 40 Developmental Assets

<http://www.search-institute.org/>

An extensive website dedicated to health promotion and development of positive assets and resilience among children and adolescents.

The Collaborative for Academic, Social and Emotional Learning: CASEL

<http://casel.org/home/index.php>

A national organization dedicated to advance the scientific based practice of social emotional learning.

UCLA School Mental Health Project: Center for Mental Health in Schools

<http://smhp.psych.ucla.edu>

A national center dedicated to promoting mental health services in public schools.

Reference List on Resilience in Children: Ohio State University College of Education

<http://altd-mh.org/hottopic/resilience/resiliencetopic.html>

University of Kansas - Slide Show on Facts About Studies on Resilience

<http://www.Kaimh.org/slides/resilience>

Traditional Native Culture and Resilience

<http://education.umn.edu/CAREI/Reports/Rpractice/Spring97/traditional.htm>

Parenting Organization

<http://www.parentinginformation.org/>

Centre for Research on Education, Diversity and Excellence (CREDE)

<http://www.cal.org/crede/>

II. Workshop 21. Thursday, Dec.12, 2013 8:30-11:30

TREATMENT OF INDIVIDUALS WITH ANGER-CONTROL PROBLEMS AND AGGRESSIVE BEHAVIORS: A LIFE-SPAN TREATMENT APPROACH

Most forms of aggressive behavior begin in child and adolescence and is relatively stable over the life-span. In this presentation, Dr. Meichenbaum will consider:

- 1. a life-span perspective of how aggressive behavior develops and escalates and the implications for both preventative and treatment approaches; (Consider "How do you make a violent individual")**
- 2. a Case Conceptualization Model of risk and protective factors that informs treatment decision-making;**
- 3. ways to predict violence toward others , as well as toward oneself (suicidal behavior);**
- 4. the " state of art" of providing evidence-based treatment of aggressive individuals;**
- 5. specific ways to implement the Core Tasks of Psychotherapy with angry and aggressive clients;**
- 6. provide guidelines on how to increase the likelihood of generalization and maintenance of training (How to not just " train and hope " for transfer). The attached Handout includes a Patient Self-assessment Checklist of what he/she learned from treatment.**

A video of clients with angry and aggressive behaviors will be presented and ways to conduct a variety of cognitive behavioral interventions. See Meichenbaum's Clinical Handbook on "Treating individuals with anger-control problems and aggressive behavior" for a detailed description of treatment approaches. For example, see Appendix A for a manual on " How to turn an aggressive youth into a social problem solver".

For a video demonstration of this intervention with an angry adolescent see Jim Larson <http://facstaff.uww.edu/larsonj/video.html>

FOR A DISCUSSION OF THE DEVELOPMENT OF AGGRESSIVE BEHAVIOR SEE THE HANDOUT ACCOMPANYING TOPICAL PANEL 3 CHILDREN AND ADOLESCENTS

**TREATMENT OF INDIVIDUALS WITH ANGER-CONTROL
PROBLEMS AND AGGRESSIVE BEHAVIOR
HOW TO USE THIS HANDBOOK
(COST \$65)**

It is not expected that this HANDBOOK will be read from cover to cover, but rather will be used as a Reference Guidebook like a fine cookbook. The connoisseur will on multiple occasions for suggestive guidelines. But like the “expert” chef, the creativity alter the recipes and procedures to meet his/her needs. In order to fax this referral process, the following list of CONTENT is offered. Also, see the SUBJECT (p.446).

I WANT TO LEARN MORE ABOUT OR HOW TO:

- | | |
|---|--|
| <p>Conduct APPLICATION TRAINING (p. 341)
Conduct ASSESSMENT (p. 132)
Conduct ATTRIBUTION TRAINING (p. 347)
Formulate CASE CONCEPTUALIZATION MODEL (p. 82)
 Examples: Intimate Partner Violence (p. 108)
 Juvenile Offenders (p. 83)
“DEFUSE” ANGRY INDIVIDUALS (p. 400)
Consider EPIDEMIOLOGY (p. 26)
Conduct COGNITIVE RESTRUCTURING (RETHINKING PROCEDURES) (p. 299)
EDUCATE PATIENTS (p. 250)
Identify CORE TASKS OT THERAPY (p. 204)
Train FRONTLINE STAFF (p. 192)
Understand GENDER DIFFERENCES (P. 71)
Foster GENERALIZATION (p. 334)
Employ GESTALT-BASED ASSESSMENT (p. 178)
Conduct GOAL ATTAINMENT SCALING (p. 238)
Conduct GOAL SETTING (p. 227)
Conduct INTERVIEWS (p. 147)
 Examples: Clinical Interviews (p. 150)
 Life Space Crisis (p. 166)
Use IMAGERY-BASED ASSESSMENT (p. 167)
Employ IMAGERY-BASED ASSESSMENT
Employ LETTER WRITING/JOURNALING (p. 309)
How to MAKE A BATTERER (p. 118)
 JUVENILE OFFENDER (p. 54)
 TERRORIST (p. 130)</p> | <p>Examine META-ANALYSES
 Child (p. 201)
 Adult (p. 199)
Examine PATIENT HANDOUTS (p. 12)
 Consider PREVENTATIVE PROGRAMS (p. 122)
Code PROVOCATIONS (p. 264)
Assess PATIENT SATISFACTION (p. 354)
Conduct PROBLEM-SOLVING TRAINING (p. 311)
Conduct RELAPSE PREVENTION (p. 355)
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 Identify RESILIENCE FACTORS (p. 77)
Conduct ROLE PLAYING (p. 329)
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 Examples: Communication Skills (p. 317)
 Interpersonal Skills (p. 324)
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Employ SOCIAL INFORMATION PROCESSING MODEL (p. 35)
Conduct SELF-INSTRUCTIONAL TRAINING (p. 284)
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 Psychiatric Patients (p. 179)
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**TREATMENT OF INDIVIDUALS WITH ANGER-CONTROL PROBLEMS
AND AGGRESSIVE BEHAVIORS: A LIFE-SPAN TREATMENT
APPROACH**

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Anger is an internal experience comprised of emotional, physiological and cognitive components. Dysfunctional anger is out of proportion, overreaction that varies along a dimension from mild feelings of annoyance and irritation to moderate frustration to feelings of fury and rage. Anger may arise when there is a discrepancy between the way things are and the way you would like them to be, or when there is a perceived “inequity” or “injustice” (violate a sense of fairness and honor, or code of conduct).

Anger and aggressive behaviors are transdiagnostic that occur across a wide variety of psychiatric disorders. For example, psychotic patients who have delusions, command hallucinations, patients with emotionally unstable mood disorders like depression, and anxiety, PTSD, patients with impulse control disorders, intellectual disabilities, Traumatic Brain Injuries, Borderline and Antisocial Personality Disorders.

Individuals can become attached to their anger routines. Aggressive behavior often “works” in accomplishing short-term goals. These may include the reduction in tension, increased sense of power, feelings of not being taken advantage, silences negative feedback, forces others to avoid unpleasant topics, gets others to comply with one’s wishes and desires, and achieves instrumental goals.

Anger may be reactive to events and perceived provocations or directive and instrumental in obtaining power, position, and property.

THINKING PROCESSES OF ANGRY AND AGGRESSIVE INDIVIDUALS
(See Meichenbaum, 2002)

1. Perception of a provocation, threat, or insult that can set off a “vicious cycle” - - feelings of disrespect, loss of honor, manhood, humiliation, frustration, anger and the like.
2. Attribution of intentionality - - done “on purpose”. Hold a “hostile attribution bias”.
3. Call upon mental heuristics in a mood congruent fashion of other such “insults” and “provocations” (Old anger rekindled). Hold a “fixed” mindset. Beliefs unlikely to change.
4. Hold stereotypes and deindividuate, dehumanize others as “infidels,” “evil,” “jerks,” use pejorative prejudicial labels.
5. Use historical analogies, metaphors, “like a” statements that exclude the possibility of negotiation, compromise, perspective taking and compassion.
6. Elicit a belief system (Code of Honor, Moral Imperatives, Sacred Beliefs) that rigidify thinking and behavior.
7. Engage in dichotomous thinking (“with us” or “against us”) that pulls for justification for revenge (“Eye for an eye” “She hurt me, so I am justified to hurt her back”). Hold an implicit theory of justice that displaces responsibility. Normalize aggression. Use labels such as “ethnic cleansing”, “doing God’s work”, “collateral damage”, “freedom fighter”. Reframing aggressive acts.
8. Collective identity that other members of one’s group are even more extreme and share similar cultural norms and beliefs. Justifying “story telling” of entitlement (“King of the castle”).
9. Enhance social status and material payoffs for engaging in aggressive behaviors.

USE “CLOCK” METAPHOR

12 o’clock – Triggering events which are specific, identifiable, and the sources of anger and aggressive behaviors.

External Events

- What someone did or did not do; said or did not say.
- Perceived injustice or inequity, lack of fairness, disrespectful.
- Setting conditions for triggering anger may be physical pain, fatigue, cold, feeling sick, being hung over.

Internal Events

- Anger-related memories and images (“old anger” and prior anger).
- Ruminations (“not let it go”). Harbor grudges.
- Triggered by other emotions (anxiety, depression, physical pain)
- Feelings of being rejected, humiliated, embarrassed.
- Pre-anger state can act as an “interpretive filter”.

3 o’clock – primary and secondary emotions

- Feelings vary along a dimension of being annoyed, irritated, moderately frustrated to being enraged and furious.
- Physiologically aroused (elevated heart rate, tense muscles, hot sensations, secretion of hormones like cortisol levels that contribute to a sense of power).
- May feel distressed, overwhelmed and overtaxed that can exacerbate feelings of frustration and anger.
- Anger can be a secondary emotion resulting from feeling rejected, humiliated, embarrassed, threatened, misunderstood, disrespected, dismissed.
- Feeling out of control can contribute to a negative view of self (guilty, ashamed).
- Anger is a “moral emotion” where individual feels justified, righteous, right.

6 o'clock – mindset and thinking processes (automatic thoughts and images; thinking processes; and core beliefs or schemas).

- Attribution of intentionality. Perceived events as having been done “on purpose”. Have a hostile attribution bias.
- See events and behaviors as preventable and controllable. Could have and should have been prevented or avoided.
- See events and behaviors as unwarranted - - unjust, unfair and undeserved.
- Blameworthy - - blame individuals, groups, organizations responsible who deserve punishment, suffering, warrant restitution and compensation. Reinforces rumination, suspiciousness, cynicism. Minimize personal responsibility and accountability. Anger and aggressive acts are justified.
- Violate expectations, sacred values, code of conduct and honor, social and cultural norms, trespass rules of living, Religious beliefs, deep seated attitudes, assault on “ego identity” (sense of manhood) and “moral imperatives”.
- Exaggerate the seriousness of the violation of being harmed. Out of proportion reactions.
- Engage in black and white, dichotomous thinking.
- Use inflammatory, denigrating, dehumanizing prejudicial thinking and labeling. Use stereotypical name calling. Deindividuate others. Blame the victim.
- Hold perfectionist standards. Highly judgmental.
- Have an attitudinal disposition of hostility, mistrust and cynicism. Contributes to revengeful and retaliatory thoughts and images. Harbor grudges. Committed to get even. “Eye for an eye, tooth for a tooth.” No room for forgiveness, perspective taking, or compassion.

Examples of Automatic Thoughts

“This is awful, unbearable, intolerable, unimaginable.”

“I can’t take it anymore.”

“I am at the mercy of my anger.”

“I have always been hot-headed. It runs in my family.”

“I am a hot responder. It is like my family had a high thermostat for anger that I inherited.”

“I get caught up in these arguments.”

“I hold onto my anger. Where I live, it is a survival skill.”

“I have no other choices.”

“Tyranny of shoulds. This should not have happened.”

“Nobody should have to take this crap; not have to deal with this.”

- Demandingness - - Wishes become commandments, imperatives to act, rather than preferences. Blind to blind spots.

“Do it because I said so.”

“This is the way it is done.”

9 o'clock - - Behavior and resultant consequences

Verbal aggression – express strong dissatisfaction and displeasure, engage in name calling and cursing, arguing, yelling, threatening

Behavioral aggression – various forms of aggressive acts like stalking, using subterfuge, sabotage, stalling

Relational aggression – start rumors, exclusion, inappropriate withdrawal, pouting, brooding

Engaging in reckless behaviors becoming intoxicated, driving recklessly, gambling, shopping and engaging in acts designed to hurt others

ASSESSMENT : HOW ANGER IS EXPERIENCED, EXPRESSED AND ANY EVIDENCE OF EFFORTS AT SELF-REGULATION

("Meet the patient where he or she is")

Clinical Interview

Use open-ended questions that are exploratory and that convey high empathy, are respectful and validating of the client's experience and that nurture rapport.

Use Questionnaires (See list below)

Self-monitoring training procedures- Anger log

Use the "clock" metaphor to change the client's relationship with angry thoughts and feelings.

Use role-playing – Use Gestalt two-chair.

Assess for developmental history of angry and aggressive behaviors and family history (intergenerational transmission). Change the client's relationship with and response to uncomfortable and painful aspects of history.

Assess for presence of comorbidity, especially probe for the role of substance abuse (alcohol). Other comorbid disorders include depression and accompanying suicidality, generalized anxiety disorder, PTSD, ADHD and Borderline and Antisocial Personality Disorder and Traumatic Brain Injuries.

Assess Safety Issues - - availability of weapons, weapons history, trouble with the law, occurrence of family violence, increased risk of accidents (aggressive driving), role of substance abuse.

Conduct a Functional Analysis of Angry/Aggressive Behaviors - - intensity, frequency, duration, situational variability, external and internal triggers, degree of rumination (not let go of the struggle, tug of war interactions) and efforts at self-control.

Assess for strengths, signs of resilience, values and successful efforts of self-control. Help the clients rediscover what truly matters. Clarify values that are "lighthouses" or "compasses" that show the client the direction they want to move in.

Use a Case Conceptualization Model of risk and protective factors and provide the client and significant others with feedback that informs treatment decision-making.

ASSESSMENT INSTRUMENTS

State-Trait Anger Expression Inventory II (STAXI) (Anger out and Anger in responses)	Spielberger, 1999
Anger Disorders Scale	Di Guiseppe & Tafrate, 2004
Novaco Anger Scale and Provocation Inventory	Novaco, 2003
Anger Treatment Readiness to Change Questionnaires	Williamson et al., 2003

Questions to be Raised as a Follow-up to Self-report Questionnaires

“When you were reporting your angry feelings on the Questionnaires, were there some recent angry episodes that came to mind that you can report?”

“Is your anger getting you what you want?”

“In what ways has this behavioral pattern of angry and aggressive behavior been useful to you?”

“In what ways has it been a problem for you and others?”

What is at stake if you do not change how you behave?”

“How do you think others might feel and react, if they were treated the typical ways you react and behave?”

“If your anger weren’t such a problem for you (or if you could make your anger just disappear), then what would you be doing differently?”

“How do you think others in your life might feel and react if you made those changes?”

“If your anger was not such a problem for you, what would your daily life be like?”

“You seem concerned about your anger and recognize that anger and aggressive behaviors destroy relationships. Am I correct in seeing that you want to begin to change?”

HOW EFFECTIVE ARE COGNITIVE-BEHAVIORAL INTERVENTIONS FOR ANGRY AND AGGRESSIVE INDIVIDUALS?

There are 7 meta-analyses (Beck & Fernandez, 1998; Del Vecchio & O'Leary, 2004; Di Giuseppe & Tafrate, 2003; Edmonson & Conger, 1996; Gansle, 2005; Sukhodolsky et al., 2003; Tafrate, 1995). These meta-analyses yield medium to strong effect sizes, indicating that 75% of those individuals receiving anger treatment improved compared to controls. Populations treated include angry-involved medical patients; angry community volunteers; angry aggressive drivers; vets with PTSD and comorbid disorders; generally angry college students; angry aggressive offenders with comorbid substance abuse disorders; batterers; young mothers at risk for child abuse; individuals with intellectual disabilities; individuals with traumatic brain injuries.

TREATMENT OF ANGER/AGGRESSIVE BEHAVIOR

(See Chemtob et al, 1997; Deffenbacher & McKay, 2000; DiGiuseppe Tafrate, 2001; Kassino & Tafrate, 2003; Meichenbaum, 2001)

Phase I: Initial Education and Conceptualization

Establish a therapeutic alliance, build rapport and trust and address motivation

Conduct assessment and provide feedback (Interview, self-report measures, self-monitoring).
Conduct situational developmental assessments.

Enhance client's personal awareness (Consider developmental and family of origin patterns, use imagery reconstruction, role playing).

Collaboratively develop a Case Conceptualization and a treatment rationale;
Collaboratively conduct mutual goal setting.

Educate patients about the components and functions of anger and relationship to stress and aggression. Distinguish between "healthy" and "disturbed" forms of anger.

Nature and functions of anger (Highlight that anger is a normal human reaction to a variety of insults and that angry-feelings have both positive and negative consequences). **Negative** in the form of social, personal and physiological consequences (e.g., individuals with high levels of anger and hostility are at high risk for coronary heart disease). **Positive** consequences in terms of warning someone that something is wrong and that some form of self-protective action is called for or that there is a need to correct an injustice.

Individual profile - - help the patient to identify the chain of angry emotions, thoughts, and behaviors and obtain information about specific anger-evoking triggers. Educate inductively about perceived provocations - - **ICE HOPE** For example, have the patient tell, imagine, or act out a "story" of the provocation-anger response. Along the way, ask the patient to identify and rate his/her feelings. At various points the therapist can ask, "*At that point how did you feel?*"; "*How much did you feel that way?*"; "*What were you thinking?*" Construct a Personal Anger Provocation Hierarchy that includes information about:

Triggers- physical, emotional, cognitive, behavioral (sources of anger and accompanying beliefs) "**What lights the patient's fuse?**"

Early warning signs- intra and interpersonal cues that indicate he/she is becoming angry and that his/her behavior is escalating toward violence

Setting events- identify high-risk situations (where, when, with whom)

Role of exacerbating factors - alcohol, drugs, presence of peers

Role of coping responses – ways to help the patient identify existing “strengths” or abilities in anger management and conflict resolution. Ask the patient about a time he/she felt angry or, mad, but handle the anger in an “effective” and “reasonable” way. This discussion should start with “something positive”.

Move to a problem-solving mode. Highlight that the patient has options in order to increase his/her sense of personal control.

- a) Help the patient view “provocations” and “personal threats” as “problems-to-be-solved” and to adopt a problem-solving orientation.
- b) **Intrapersonal** (e.g., what coping techniques used)
- c) **Interpersonal** (e.g., discuss the value of sharing feelings about troubling events such as quarrels, relationship conflicts, or more serious incidents with a supportive)

Phase II: Skills Training and Stress Inoculation Training

Teach patients how to:

- 1) **manage physiological arousal** and learn ways to lower bodily tension;
- 2) **develop emotional-regulation and self-control skills** (identify provocation situations to which they are vulnerable, self-management relaxation training, taking time-out, self-instructional training by means of behavioral and imaginal rehearsal, cognitive-restructuring, role playing. Use in-clinic and in vivo practice);
- 3) take **constructive action** on precipitants of anger whenever possible (problem solving, communication, bargaining, assertive, parenting, skills training, and the like);
- 4) employ **distraction** and **emotional-palliative** coping techniques when no constructive action is possible (e.g., use vigorous physical exercise, talk about angry incidents with a confidant, use acceptance skills, incorporate “forgiveness”).

Arousal reduction techniques including applied relaxation training – use slow deep breathing, cue-controlled relaxation which includes the use of calming imagery and slowly repeating the word “relax” and relaxing more with each repetition. Help the patient learn how to switch-off anger images and anger-engendering self-dialogue and learn to visualize relaxation images. (Note, relaxation training usually precedes cognitive-based intervention by 2 or 3 sessions)

Build in “homework” or “commitment” exercises between sessions (address concerns about adherence-practice initially in non-stressful situations; use a hierarchy of imaginal coping scenes). Eventually, **practice in vivo**.

Use taking time-out procedures- involve and educate significant others about time-out. Use self-instructional training- patients are encouraged to generate their own self-statement package and self-control scripts

Use coping guided imagery training- use hierarchical scenarios from mildest to most anger arousing. How to change one’s image so the patient is only “bothered”, “irritated”, “annoyed”, instead of “enraged”.

Use role playing (“Barb” or challenge techniques).

Use stress inoculation training (See Meichenbaum, 2001).

Phase III Cognitive Restructuring and Problem-solving

Foster cognitive change – address cognitive distortions, exaggerations, thinking style, black-white thinking, suspiciousness

Use cognitive restructuring or “rethinking” procedures – focus on reappraisal and reframing. Used evidence-based, alternatives, and implications questions; use Socratic questioning and a two-chair dialogue to help the patient differentiate the two sides of a conflict.

Address the patient’s beliefs about trust, fairness, injustice, entitlement (i.e., what they see as their “issues”, values, convictions). See the world as less conflict-oriented.

Conduct a developmental analysis of the origin of beliefs. Intergenerational and cultural transmission of belief systems and expressions of anger. Consider the role and impact of victimization. Treat comorbidity of anger, aggression, namely, substance abuse, affective disorders, PTSD (e.g., Meichenbaum, 1997, 2001; and Najavits, 2002 Seeking Safety: An integrated treatment approach).

Use coping modeling procedures – initially show videotape of individuals losing control. Have patients analyze these scenes and then generate alternatives. Then show coping models. Analyze and rehearse coping responses. Therapist can use Think-aloud and ask patients how angry they would feel if they were thinking in this manner. Consider alternative ways of thinking and behaving and possible benefits. Therapist can demonstrate and model anger coping responses in provocation situations that arise in therapy.

Problem-solving intervention (Goal, Plan, Do, Check) Teach problem-solving skills.

Social skills enhancement (listening, communication, conflict resolution, assertiveness,

negotiating to resolve a problem, parenting, supervisory skills). Discuss what strategies to use at what phase of the de-escalation cycle (e.g., communication skills training such as the use of “I” statements than “You” statements).

Discuss the **“wisdom” of postponing discussion** of conflictual issues until a more opportune time. Learn how to “edit” what one says.

Use humor as a way to vent anger, but discuss when and how to use it appropriately.

Use application training (imaginal role-playing and behavioral rehearsal of simulated graduated exposure responses); apply coping skills under conditions of increased anger arousal. *Use “barb” techniques*. **Implement behavior change and build in generalization procedures.**

Train coping skills in conjunction with progressive exposure to graduated doses of provocations in a therapeutic setting and eventually in-vivo.

Incorporate external prompts and consequences into treatment program.

Have the patient **work to rebuild relationships**.

Enlist peers and family members as “allies” in the treatment process. Encourage the patient to spend time with people who support the changes they are making.

Phase IV: Review and Plan for the future

Self-attribution procedures – ensure that patients **“take credit”** for the changes they have implemented. Nurture a **“NEW ME”**.

Relapse prevention procedures – identify high-risk situations, early warning signs, and collaboratively develop plans and back-up plans of action; point out times of vulnerability to excess anger.

Include follow-through and booster sessions.

The treatment should be applied in a flexible manner, not in a lock-step progression. Phases of treatment overlap and are not implemented sequentially. **The length of treatment usually varies between 6 to 20 sessions.** The number and timing of the treatment sessions are individually tailored to the needs of the patient. Monitor the patient’s progress and use this information to guide ongoing treatment. In general, the sessions are:

- (1) once a week and in more severe cases initially twice a week;
- (2) eventually thinned out (every other week, once a month, once every 6 weeks, once every 2 months);

- (3) supplemented with the use of booster sessions. Booster sessions can be conducted on an individual, group, couple, or family basis.

In some instances, the trainers may be selected and trained from the participant groups (e.g., police officers, marine drill-instructors, vets, adolescents) who have gone through the training. Individual therapy has been found to be more effective than group therapy (DiGuiseppe & Tafrate, 2001).

PATIENT CHECKLIST: WHAT I HAVE LEARNED AND WILL CONTINUE TO USE

As a result of participating in treatment, I have learned the following skills. I can give examples of each and also indicate the reasons why using each skill is important in achieving my treatment goals. I can anticipate any barriers/obstacles that might get in the way of trying these skills and activities. I can tell you “where, when and how” I can use these behaviors. Finally, I can indicate the level of confidence (from 0% to 100%) that I will be able to do these activities.

1. Be on the lookout for possible triggers and events (people, places and things) that trigger my anger and aggressive behaviors.
2. Avoid people and situations likely to lead to anger and aggression.
3. View provocations as problems-to-be-solved, rather than take these personally. Lessen my reactivity to triggers and increase my tolerance for frustration.
4. Lower my perfectionistic standards and be less judgmental. Search for solutions that are often less than perfect. Watch without judging.
5. Be less demanding. Do not “should on my head” and stop “musterbating”. (Tyranny of “shoulds” and “musts”).
6. Notice the warning signs of when I am getting upset and angry.
7. Recognize, name and tame my feelings. Develop self-control to handle my emotional reactivity (“lengthen my fuse”), exert impulse control and handle my susceptibility to peer influences.
8. Conduct my “Clock Analysis” in order to see the connections between my feelings, thoughts and behaviors.
 - 12 o’clock - - external and internal triggers
 - 3 o’clock - - primary and secondary emotions
 - 6 o’clock - - automatic thoughts/images, thinking patterns and underlying beliefs
 - 9 o’clock - - behavioral acts (what I do) and how others respond
9. Take action to break my “vicious cycle”. (Use my Clock Analysis).
10. Make sure I am not responding to “old anger”, memories of past insults, carrying grudges.
11. Monitor my moods and accompanying thoughts. Change my self-talk and mindset. Challenge, test and change my thoughts and thinking processes. Don't look for hostile intent (Done to me “on purpose”). Think through the consequences (costs and benefits of antisocial and prosocial acts).

12. Keep track of my anger. Use my Anger Log. Increase my awareness.
13. Identify my personal goals and values and ask myself, “What is really important?”
14. Remind myself that anger destroys relationships. Ask myself, “Is anger getting me what I really want?”
15. Ask myself, “Who appointed me God?” Be aware of the paradox. “I have a right not to comply with other people’s requests, but I expect other people to do exactly what I request.”
16. Ask myself, “How do I think others feel when I treat them in this manner?”
17. Face anger with compassion. Take stock of the situation. See it from the other’s perspective. Develop an observer’s perspective.
18. Take a time out. Use exit lines and call a time in.
19. Use my relaxation skills - - breathing techniques to reduce my arousal level. Not allow my amygdala (lower brain) to “hijack” my emotions and thinking processes.
20. Appraise anger with mindful acceptance, gentle awareness, and distraction. Use my self-soothing techniques.
21. Incorporate forgiveness. Learn to let anger go, release grudges and “move on”. Forgiveness and compassion leaves anger with no room to grow.
22. Use my verbal skills (communication, negotiation and assertiveness skills).
23. Use my “I” statements, instead of “you” (accusatory) statements.
24. “Edit” what I say. Not have to say every thought I have. Break behavior- thought fusion.
25. Mentally rehearse (think through ahead of time), how I can handle a difficult and challenging situation. Use my Goal-Plan-Do-Check Protocol. Use Future Imagery Procedures.
26. I can take “Response-ability” (responsibility) and make choices. Think about the consequences to me and others.
27. Recognize that substance abuse, like alcohol, can shorten my fuse and trigger aggressive behaviors. Reduce “risk” factors.
28. Develop the willingness and courage to “sit with my anger” and not act upon it.
29. Be able to “notice”, “catch”, “reward myself”, “and take credit for changes I have made”, “show others /tell others what I have learned.”

30. Ask for help from “safe” people (family, friends, my therapist, chaplain) and develop meaningful relationships. (“Give to get”).
31. Implement my “safety” plan. Create an “If..then” and “Whenever... if” backup plan, to be used if my anger is getting out of control.
32. Restructure social ties and develop "social capital". (Value I find in my social network of friends, extended family members, parents, people in community groups, fellow students and coworkers).
33. Change my daily routines and activities in order to "stay out of trouble" .
34. Adopt new social roles such as loving romantic relationships, start a family , engage in steady employment that yields " respect", engage in job training in order to develop marketable skills, join the military, associate with pro-social community members in church or sports, hobbies, and actively engage in psychotherapy or training.
35. Take pride in what I have been able to achieve, “in spite of” possible provocations, stressors, social pressures, challenges to my code of conduct, and sacred beliefs. Exert personal agency and confidence in my ability to control my choices and behavior.
36. Make a “gift” of what I have learned and share it with others.
37. Develop a future orientation. Create more joy in my life.
38. Recognize that I am on a “journey”, but not alone in creating a “Life that is worth living.” Maintain hope and demonstrate the “courage to change” and create a “positive lifestyle.” I have learned to “keep on keeping on.”
39. Other things that I have learned include _____

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III Dialogue 2. Friday Dec 13 8:00 am to 9:00 am

**EXPERTISE AND PSYCHOTHERAPY: WHAT ARE THE CORE TASKS
OF PSYCHOTHERAPY**

In this dialogue with SCOTT MILLER he will consider:

- 1. research that highlights the controversies over meta-analytic studies of the relative effectiveness of various psychotherapeutic approaches, especially when evidence-based interventions are compared with "bona fide" comparison groups that are designed to succeed; (See the meta-analysis by Baardseth et al. 2013; Luborsky et al. 2002; Smith & Glass, 1977; Wampold et al. 1997; VERSUS Budd & Hughes, 2000; Hunsley & Di Giulio, 2002; and Tolin, 2010)**
- 2. enumerate the core tasks that characterize "expert" therapists who obtain the best treatment results; highlighting the critical role of therapeutic alliance (See the enclosed chapter)**
- 3. comment on the future of psychotherapy using computer technology as an adjunctive tool. (See the enclosed paper on "The future of psychotherapy using computer technology")**

The following Handouts summarize these points.

**CORE TASKS OF PSYCHOTHERAPY: WHAT “EXPERT” THERAPISTS
DO**

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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, empathic, validating message. Meet the patients where they are “at” and guide them to what may be more beneficial for them. Follow their lead and take things slowly and be patient.**
- 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 analyses.**
- 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. Encourage positive expectations that psychotherapy can be beneficial in facilitating change.**
- 10. Use Motivational Interviewing procedures (Express Empathy, Avoid Argumentation, Develop Discrepancy, Support Self-efficacy) that can impact their willingness and commitment to change.**
- 11. Conduct ongoing psycho-education in order to help them become more aware of the determinants of their behavior and the interconnections between their feelings, thoughts, behaviors and reactions of others. Use A “Clock” metaphor of 12 o’clock referring to external and internal triggers; 3 o’clock referring to primary and secondary emotions; 6 o’clock referring to thinking process (automatic thought and**

images, thinking processes and schemas/beliefs, expectations and attribution; 9 o'clock referring to their behaviors and reactions of others and how these contribute to a "vicious cycle". Increase the client's self-awareness of how he/she inadvertently, unwittingly, and unknowingly produce reactions in others that confirm their 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 therapist's possible contributions to alliance problems. Attend immediately to any strains or "ruptures" in the alliance that can lead to treatment failure.
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. Encourage and challenge the clients to take a risk in how they behave in the hope of finding results with more positive consequences, or "data" that they will take as "evidence" to unfreeze their beliefs about themselves, others and the future.
22. Conduct relapse prevention and self-attribution training ("Taking credit" activities).

- 23. Help the client become his/her “own therapist”/”detective”. “Restory” one’s life.**
- 24. Prepare for termination (Taking stock of changes and planning for the future).**
- 25. Engage in psychotherapist self-care behaviors and experience “vicarious resilience”.**
- 26. Work to enhance mastery by means of deliberate practice and self-reflection.**
- 27. Behave in an ethically responsible manner. (Respect boundaries and be aware of psychological treatments that cause harm).**

OBSERVATIONS ON CORE PSYCHOTHERAPEUTIC COMPETENCY SKILLS

Donald Meichenbaum, Ph.D

1. Establish, maintain and routinely monitor therapeutic alliance (TA).

The TA is the most robust predictor of therapy outcomes. The amount of change attributable to TA is seven times that of the specific treatment model, or specific treatment techniques. The specific treatment accounts for no more than 15% of variance of treatment outcomes. In comparison, some 36% to 51% of the treatment outcome variance is attributed to the person of the therapist, which is 3 to 4 X that of the specific treatment approach. Moreover, it is not therapist demographic factors (gender, ethnicity, discipline, or experience) that is predictive of treatment outcomes (Bordin, 1979; Horvath et al, 2011; Sperry & Carlson, 2013; Wampold, 2006).

TA consists of three major elements:

1. the therapeutic bond and the feeling that there is good communication and the mutual willingness to work together, established between the client and the therapist (mutual liking);
2. mutually agreed upon treatment goals;
3. mutual agreement on the methods to achieve the client's treatment goals ("pathways thinking" and being "practically optimistic").

As Goldfried observed (2013, p. 865) the client should hold the belief: "My therapist really understands and cares about me" and the therapist should hold the belief: "I really enjoy working with this patient." The alliance represents the context in which the change process occurs (Castonguay & Beutler, 2006; Muran & Barber, 2010).

2. Actively communicate an accepting, supportive, helpful, empathetic, validating message.

The client's trust and confidence in the therapist that he/she is competent and interested in the client's well-being is predictive of outcome. The client must feel safe, hopeful and consider the therapist as trustworthy and nurturing in order to set the stage for the client's self-disclosure of painful emotions and intimate details. The client must feel accepted, valued, understood, supported, hopeful and confident that treatment will be helpful.

"Patience is part of the key to being an effective psychotherapist. Let things happen that happen. Let people find their own comfort. Allow them to learn through struggle. Don't rescue, just support. (Beutler, 2001, p.215).

An effective TA may develop as early as the first session, but an effective TA must be firmly in place by the third session if treatment is to be successful. High TA leads to better treatment and greater likelihood of maintaining change (Skovholt & Jennings, 2004; Sperry & Carlson 2013). Note however, that the improved quality of the therapeutic alliance can follow from behavior change, especially as the treatment sessions progress. Problems in the therapeutic alliance can undermine the efficacy of therapy outcomes. In about 5 % to 10% of cases clients may get worse as a result of psychotherapy (Goldfried , 2013).

The client's evaluation of the quality of the psychotherapeutic relationship is a better predictor of the TA and treatment outcome than is the psychotherapist's evaluation of TA (Castonguay et al., 2010; Horvath et al., 2011).

“It is the therapist and not the treatment that influences the amount of therapeutic change that occurs. Relationship skills or developing a therapeutic alliance is the cornerstone of therapeutic excellence” (Sperry & Carlson, 2013).

3. Use feedback-assisted treatment. Obtain feedback on a session by session basis.

Use Rating Scales and Socratic probes and adjust treatment accordingly (see Duncan, 2010; 2012; Duncan et al. 2003; and work by Lambert (2007) and Miller as summarized on www.heartandsoulofchange.com). These are a four item scale that takes two minutes to complete that cover such areas as how well understood and respected the client felt, and whether the therapist worked on what the client wanted, how good is the “fit” and the degree of change in key areas.

The client's subjective experience of change early in the treatment process is a good predictor of treatment success (Norcross, 2002; Orlinsky et al. 2004).

4. Provide the client with Corrective Experiences both within and outside of therapy.

As Alexander and French (1946) had proposed, encourage the client to “reexperience old unsettled conflicts with a new ending.” A number of researchers have highlighted that a key feature of behavior change is to help clients increase their awareness (“behavioral pattern recognition”) and then to give themselves permission to take a risk of behaving differently that elicits results (“data”) that disconfirms their prior expectations. Use gradual exposure-based treatment, where indicated. Nurture a process of “transformation” (See Castonguay & Hill, 2012; Fraser & Solovey, 2007; Good & Beitman, 2006; Goldfried, 2012; Meichenbaum, 2013; Sperry & Carlson, 2013).

5. Prepare for termination and help the client become his/her “own therapist”.

Provide opportunities for intermittent retrospective “taking stock” throughout treatment. Nurture the client’s self-attributions or “taking credit” for behavior change. This naturally transitions into preparing for termination. Tasks to accomplish include:

Relapse Prevention training - - plan and develop self-control skills to prevent relapse.

Analyze potential high-risk situations and how to view setbacks and lapses as “learning opportunities”.

Discuss possible future challenges.

Ask “How different ?”, “What learned ?” questions. Have clients fill out checklists and provide examples and reasons.

Listen for the client’s use of “meta-cognitive transitive verbs” (“notice, catch, plan, choose”) and use of RE verbs.

Discuss a self-therapy approach, “Become your own therapist”.

Discuss life-style balance and changes.

Consider graduation ceremony, if part of a group. Include acknowledgement of accomplishments.

Consider “unfinished business” and use a journey metaphor.

Transform into meaning-making and give back activities.

Bolster self-efficacy by helping the client to embrace negative emotions as signals to examine behavioral patterns and associated expectations. (Use “Clock” metaphor).

Consider possibility of future treatment.

Ensure that learning is “fun” - - put the client in a consultative mode to teach others.

THE ULTIMATE GOAL OF TREATMENT IS TO HELP THE CLIENT TO BECOME HIS OR HER OWN THERAPIST

6. Use the Art of Discovery-Oriented Socratic Questioning Throughout

A) Examples of Questioning - - Focus on “What” and “How” Questions

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

“I would like to find out what you have tried in the past so we can benefit from those experiences. What worked? What did not work, as evident by? What were you satisfied with that you think we can build upon?

“If we worked together, and I hope we can, how would we notice if we were making progress? What would we see changed? What would other folks notice?”

“Permit me to ask one last question. Can you foresee, envision anything that might get in the way of our working to achieve your treatment goals?”

B) Questions designed to help clients become their “own therapist”.

“Let me ask you a somewhat different question. Do you ever find yourself out there, in your day to day experience, asking yourself the kind of questions that we ask each other right here in therapy?”

The treatment goal is to have the client become his or her own therapist and to take the “psychotherapists voice” with him or her.

C) Embed questions with “So far”, “As yet”, “In spite of” followed by “How” and “What” questions. Use the language of becoming and nurture a sense of possibility.

D) Questions designed to solicit feedback.

“Are our sessions meeting your needs and doing the kinds of things you would have hoped to accomplish?”

“Is there anything else that you think I can do that might be helpful that I am not doing?”

“As you look back on our work together, what stands out? Are you surprised at all with these changes?”

“On a scale of 1 to 10, where 1 is dissatisfied and 10 is highly satisfied, what number would you rate our working together?”

“As a psychotherapist, I am always trying to learn to become more expert and I wonder if you have any suggestions as to how I might improve the way I work?”

“Would you recommend this type of therapy to a relative or close friend if he/she were in need? What would you say you got out of treatment that they could benefit from?”

“Is there anything I said or did or failed to say or do in today’s session that you found particularly helpful or unhelpful?”

“Are you at all surprised with these changes?”

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**A LOOK INTO THE FUTURE OF PSYCHOTHERAPY: THE POSSIBLE ROLE OF
COMPUTER TECHNOLOGY**

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Treatment of Individuals with Anger-control Problems and Aggressive Behavior

FACT SHEET: ILLUSTRATIVE FINDINGS

THE CHALLENGE

Approximately 70% of individuals in need of psychological services do not receive them.

80 million Americans live in areas of the country where there is a shortage of mental health professionals.

Only 10% of those who meet criteria for substance abuse receive treatment.

Where mental health providers are available a variety of barriers may interfere with help-seeking including transportation difficulties, costs, time, child care issues, concerns about stigma and the like.

CAN COMPUTER TECHNOLOGY HELP ADDRESS THESE MENTAL HEALTH CHALLENGES?

(See Kazdin & Blasé, 2011 for a discussion of ways to “reboot” psychotherapy and Maheu et al. 2000, 20005; Perle et al. 2011)

Consider that:

70 % of all American adults use the Internet with more than half surfing more than an hour each day.

More than 50% of Americans have some form of high speed Internet access. 60% report that they first consult online resources when seeking solutions to health problems, including mental health problems such as depression.

90% of young people in the U.S. use the Internet and 61% access it daily; 75% of 12-17 year olds now own cell phones in the U.S. 25% of young people use the Internet as a source of mental health information.

In January, 2012 there were over 500,000 APPS for the iPhone and over 10 billion downloads worldwide, according to Apple.

Munoz (2010) discusses ways that evidence-based Internet interventions can be used to reduce health disparities worldwide.

ILLUSTRATIVE APPLICATIONS COMPUTER TECHNOLOGY TO ADDRESS MENTAL HEALTH NEEDS

1. Computers have been used in the form of mental health APPS, email communication and instant messaging with clients, online chat rooms, social networking, self-help interventions, video conferencing to train therapists and provide supervision, online therapy websites, Internet therapy of direct treatment services to clients and contact with patients in between treatment sessions and aftercare.
2. A number of Internet-based psychosocial interventions have been developed and validated in the mental health area (Barak et al. 2008). These include interventions for unipolar and bipolar depression, panic disorders, phobias, PTSD and eating disorders. Overall, results support their effectiveness and their potential. Interactive programs, as compared to passive psycho-education, were found to be more effective and therapist-assisted approaches that combine face-to-face with computer-based interventions, as compared to just computer-based interventions, have been found to be most effective.

Development of APPS that can be used with iPhones, iPads, Androids and other mobile devices. These are available through iTunes. There are APPS for anxiety disorders (social anxiety, panic disorders, obsessive compulsive disorders, and PTSD); depressive disorders and suicidality. For example, there is an APP whereby depressed, suicidal patients can create a personalized HOPE CHEST where the individual can include reminders of Reasons to Live or ways to increase Happiness (“A buddy who prompts you to maintain positive activities”, Novotney, 2011a, b). Mohr (as reported by Clay; 2012) has developed smartphone sensors that track where users are and what they are doing and how it meets their behavioural treatment goals. It can also send congratulatory notes.

There are APPS that provide Ways to relax, Control anger, Moderate substance abuse, 12 Step Stop Smoking, Engage in weight loss, and over-all well being. In the areas of childhood disorders, there are APPS for social anxiety, antisocial behavior and necropsies, ways to cope with divorce and handle parental military deployment (Leis-Newman, 2011).

Another trial examined a website aimed at educating parents about prevention and early intervention (Dietz et al., 2009). The Website had information about anxiety disorders, depression, treatment options, what parents can do, and the links to other resources. The Website was found to improve knowledge and self-efficacy in handling mental health issues.

Telemedicine technology has been used to enhance the delivery of services to children and their families and to provide ongoing supervision to mental health practitioners who are conducting parent training (Funderburk et al. 2008; Jones et al. 2013). A variety of tools including email, text messages, chat rooms, twitter, videoconferencing, skypeing and social networking sites have been used to maintain real-time communication (Aguilera & Muench, 2012).

CAVAET - - there is a need to critically evaluate the efficacy of these many APPS, as there was concerns about evaluating the many self-help books that are on the market.

3. Mobile devices are also being used to assess, diagnose, treat and prevent health problems such as insomnia, smoking, diabetes, prenatal care, falls among the elderly, safe sex, physical activity, chronic disease, breast cancer and treatment adherence (Beatty & Lambert, 2013; Clough & Casey, 2011; Ritterand & Tate, 2009).

For example, Dimeff et al. (2011) report that in the near future there will be easily digestible smart pills with tiny transmitters and antenna that tracks medication adherence when swallowed and wearable body sensors that monitor health-related behaviors like smoking. For instance, a person quitting smoking might receive the following message from his or her “lungs”:

“Don’t even think about smoking. It’s been 4 hours since your last cigarette. Carbon monoxide in your blood has already dropped by half and I’m pinker already.”

4. Another way computers will be an adjunctive tool for psychotherapists is to use them to conduct in vivo ongoing assessments using mobile electronic devices (Shiffman et al. 2008; Wenze & Miller,2010). Such ecological monitoring interventions can be used to monitor mood swings, the presence of cravings, and various symptoms. They can provide personalized interventions depending upon what the individuals is experiencing at the moment.

APPS have been developed to help individuals track and share daily changes in their moods (www.mood247.com) and to receive via text messages suggestions on ways to alter their moods and cope with stressors. Dimeff et al. (2011) have developed a DBT coach (Dialectical Behavior Therapy helper). The DBT coach assesses an individual’s emotional intensity and cravings to use drugs on a 1 to 10 scale. The DBT coach then uses an Interactive format to help the individual cope more effectively. A cautionary note that some APPS that provide individuals with ways to self-monitor mood changes are sponsored by pharmaceutical companies as a means to promote the needs to use their antidepressant medication.

5. The Comprehensive Soldier Fitness program that is designed to enhance resilience in service members uses a Soldier Fitness Tracker System to provide ongoing assessment, (Fravell et al. 2011). See Meichenbaum (2012) Roadmap to resilience Guidebook for a list of supportive Websites, self-help interventions available to returning service members.
6. Computer technology has also been used with clients in the form of Electronic Questionnaires. For example, see the following illustrative Websites www.drinkerscheckup.com and www.rethinkingdrinking.niaaa.nih.gov designed to access and provide normative comparison information for substance abuse, or <http://cust.cfiapa.org/ptgi/inlax/cfm> to assess Post traumatic growth.

7. Mobile phones have been used to provide real-time in vivo feedback to the patient and his/her psychotherapist.

Such a form of patient feedback has been developed by Lambert, Miller, Duncan and their colleagues. Psychotherapists can track patient progress and identify patient's at risk for deterioration or drop out using the Electronic Outcome Questionnaire (OQ45) that compares the patient's progress to recovery curves. The OQ45 provides patient feedback in terms of psychological disturbance, interpersonal problems, societal role functioning and quality of life. This information can be sent directly to the therapist so he or she can alter intervention strategies accordingly. (See Lambert et al., 2005).

8. Use of computer technology to reduce treatment drop-out. Consider that the modal number of visits in independent practice settings is one and the rate of treatment drop-out varies around 47% across different settings. (Barrett et al. 2008). Given that 11 to 13 sessions of evidence-based interventions are required for 50%-60% of clients to be considered recovered (Hansen et al. 2002; Lambert, 2007), any computer-based interventions that can mitigate such drop-outs would enhance treatment effectiveness. One way to encourage help-seeking behavior and reduce drop-out from therapy is to use modeling films, in the form of client `story-telling`. For example, see three projects that I have been involved with (www.warfighterdiaries.com; www.MakeTheConnection.net/stories-of-connection for returning service members) and www.reachout.com for adolescents. In each instance, a Constructive Narrative treatment perspective has guided the development of these Websites (see Meichenbaum, 2012).
9. Computer technology has been used to enhance client adherence to therapy and to conduct aftercare interventions. (Clough & Casey, 2011).
10. Use of Internet therapy with a post disaster population (Benight et al. 2008; Ruggiero et al. 2006; Taylor & Luce, 2003) and with patients experiencing PTSD (Lange et al. 2003; Litz et al. 2007; Tuerk et al. 2010) and complicated grief (Wagner and Maeraker, 2007). For example, Wagner and Maeraker conducted a randomized controlled trial of the effectiveness of a five-week Internet-based cognitive-behavioral treatment program for complicated grief. The patient improvement was evident at a 1.5 year follow-up. Mohr (2012) has developed an Internet intervention for depression (see www.apc.org/monitor/digital/mohr.aspx). See Clarke et al. (2008) for a description of a self-help skills program to overcome depression and Derry-Palumbo and Zeine (2005) for examples of online therapy procedures.

Christensen et al., (2002, 2004, 2006) have conducted controlled trials using the Internet to prevent depression. The trial compared a website giving information about depression and its treatment (Blue Pages: www.bluepages.anu.edu.au) with a website providing cognitive-behavior therapy (Moodgym: www.moodgym.anu.edu.au) and an attention-placebo control intervention. The information website was found to increase the participants' understanding of treatments for depression relative to other interventions, although it did not improve professional help seeking. The information website reduced

depressive symptoms and produced effects equivalent to those of the cognitive behavior therapy website. These therapeutic benefits were found to be maintained over 12 months.

See Calcar et al. (2009) for a computer-based Youth Mood Program and Lauder et al. (2013) for an example of an intervention program with clients with bipolar disorders (www.moodswngs.net.au).

Roberts (2011) has edited the December Issue of Professional Psychology on various telehealth interventions.

11. For individuals with Substance abuse disorders, Carroll et al. (2008) have developed a social network system of (CBT4CBT) and has on-line training for therapists. Schumacher et al. (2011) have demonstrated how to train therapists in Motivational Interviewing procedures using computer technology. King et al. (2011) has developed Internet addiction treatment. See Williams et al. (2009) for a description of a web-based alcohol intervention program.

Cell phones have been built with a GPS system in them, so when an individuals who have substance abuse problems get near their favorite “watering hole” (an area where they imbibe alcohol or use drugs), the individual’s cell phone will ring and provide a variety of coping strategies.

12. Psychotherapists have treated patients via video teleconferencing serving those who live in rural areas. They provide psychological services remotely via telephone, Email or videoconferencing. Improve access to care for people who have mobility problems or for those who avoid treatment due to stigma concerns, or other barriers.
13. Use Computer Technology to Train Psychotherapists and Provide Supervision (*See Barnett et al. 2011 and June Issue Vol. 48 Psychotherapy*)

Illustrative training Websites

Cognitive-behavioral trauma-focused therapy

www.musc.edu/tfcbt

Cognitive Processing Therapy

www.musc.edu/cpt

Cognitive-behavioral approach for treating cocaine addiction

<http://www.drugabuse.gov/txmanuals/cbt/cbt1.html>.

Training in Motivational Interviewing

<http://www.motivationalinterview.org>

Discussion of Internet and Video Technology in Psychotherapy Supervision and Training see Barnett (2011) and June Issue Psychotherapy (vol.48. No 2).

14. There are also computerized therapy Rating Scales that can be downloaded and used to improve Therapeutic Alliance in individual, couple, and family treatment approaches

(See Escudero et al. 2011; McCullough et al. 2011 - - www.softa-soatif.net and www.4TOSTrainer.com).

Therapists can also access APPS that provide information of how to assess and treat individuals with Traumatic Brain Injuries, PTSD and other psychiatric disorders (Richardson et al. 2009).

15. Another form of computer technology use has been the development of immersive virtual reality psychotherapy where people don goggles and headphones and are transported into a three dimensional world that can include realistic sights, sounds and even smells that are computer-generated and controlled. For instance, one can create war-related scenes, substance abuse relapse prevention scenes, phobia-avoidant situations, each individually tailored to the needs of the client. In this way, exposure-based interventions, refusal skills, social interactive skills can be practiced by clients. A form of Second Life scenario using Avatars has also been used for training purposes (See DeAngelis, 2012 for a listing of companies that provide training on ways to use Virtual Reality Tools). The relative effectiveness of this technology needs to be established.
16. Use of computer technology as adjunctive tools to psychotherapy, especially with children and adolescents. For example, video games such as “Treasure Hunt” and “Personal Investigator” have been used with children (see www.secondlife.com). Khanna and Kendall (2010) have developed a computerized Camp-Cope-A-Lot for children who are socially anxious. For adolescents who are depressed, there are Avatar-based Beat-The-Blues Websites. See www.melissainstitute.com website for a listing of such computer based interventions (Meichenbaum, 2010 - - Adolescent depression conference). Also, see companion Website www.teachsafeschools.org for ways to address issues of bullying and cyber bullying.
17. Finally, psychotherapists have used computer and Skype technology to provide individualized psychotherapy. The use of such direct service video-based treatments has raised a number of issues of computer-based versus face-to-face treatment approaches, and concerns about safety, privacy, legal, ethical and practical issues.

ISSUES IN USING TELEMENTAL HEALTH INTERVENTIONS

(See Division 29 Report from the Task Force in Telepsychotherapy, Judge et al., 2011)

1. Issue of Effectiveness. Several meta-analytic studies have been conducted that compare Internet-based therapy versus face-to-face treatment (Barack et al., 2008; King et al., 2011; Perle et al., 2011). Also see Journal of Technology in Human Services, 26, No. 2; Clinical Psychology: Science and Practice, 2009, 16, Vol. 3. There were no statistically significant differences between Internet-based and face-to-face interventions. Video conferencing designed to deliver patient interventions showed high patient and therapist satisfaction and yielded positive treatment outcomes. Moreover, the therapeutic alliance scores in online therapy were found to be equal to face-to-face sessions. Clients tend to disclose more information about themselves to the computer, and over the Internet when

compared to face-to-face interactions. Online therapies encourage self-disclosure and reflection. Online assessments have been found to be as effective as live assessments (See Perle et al. 2011 for specific references).

Drop out rates from web-based interventions were low relative to other types of self help and face-to-face interventions.

2. Issues of Safety. When conducting Internet-based psychotherapy the issues of assessment of suicidality and crisis management are important concerns. Fenichel et al. (2002) report that computer-based measures were better predictors of suicidal feelings than face-to-face clinical interviews. There is a need to ensure accessibility to psychotherapists and emergency resources in the patient's locale when therapy is being conducted over a distance.
3. Privacy Issues and Security Concerns. Psychotherapists need to check the server to ensure for encrypted programs and protected passwords. There is a need to warn clients about the limits of confidentiality and the need for informed consent (Maheu et al. 2005; Reed et al. 2000). Ensure that HIPPA compliance rules are followed.
4. Set limits with patients. For example, do not befriend clients through FACEBOOK and limit therapist self-disclosure.
5. Check Licensure and Jurisdictional concerns across state lines. See www.apapracticecentral.org/advocacy/state/telehealth-slides for a 50-state review of telehealth laws, as well as the Association of State and Provincial Psychology Boards Website www.asppb.net. They created a credential called the Interjurisdictional Practice Certificate that facilitates temporary practice in other jurisdictions.
6. Issues of Reimbursement using telemental health interventions, insurance coverage. Should psychotherapist charge the same amount as when doing face-to-face treatment, when there are no overhead charges?
7. When is telepsychotherapy contra-indicated? Issue of patient online literacy and attitude toward computer. Use Computer Self-efficacy Scale (Manring et al., 2011). Question use of telepsychotherapy with delusional patient or with patients with Internet addiction.
8. Telepsychotherapy may be particularly helpful with socially anxious clients, or with clients who are concerned about stigma like military personnel. For instance, Tripler Army Medical Center in Honolulu have provided Internet counselling to distant service members.
9. Psychotherapists need training and familiarity using telehealth technology. How to use Skype, Google Talk, how to use eye contact. Concerns raised when psychotherapist turns away from the camera to take notes. This may be misinterpreted by the patient. Psychotherapist needs to check volume, clarity, position and other logistics. (See Abbass

et al. 2011 and Manring et al 2011 for detailed directions on how to use Webcam technology.

10. For additional discussion of issues of Informed Consent, Malpractice Insurance Protection, Confidentiality, Billing, Technical and Ethical Issues and training see the following Websites.

APA Practice Central

apapracticecentral.org/advocacy/state/telehealth-slides.pdf

National Register

www.nationalregister.org

State Licensure

<http://www.asppbinet/14a/pages/index.cfm?pageid=345>

Ohio Psychological Association

www.ohpsych.org/resources/1/files/Comm%20Tech%20Committee/OPATelepsychologyguidelines41710.pdf

Canadian Psychological Association

www.cpa.ca/aboutcpa/committees/ethics/psychserviceselectronically/

EXAMPLES OF COMPUTER-BASED PROGRAMS I HAVE BEEN INVOLVED IN

1. Work with National Guard - - Train treatment staff and create IPOD technology for returning service members and ways to reduce suicide rates.
2. Create Melissa Institute Websites www.melissainstitute.org and www.teachsafeschools.org. These have had over 2 million HITS worldwide. Project target reading instruction as a means to reduce antisocial behavior and the development of a Principal Checklist.
3. Work on ways to reduce relapse rate in clients with substance abuse using GPS cell phone technology (see www.chess.wisc.edu/chess/home/home.aspx - Centre for Health Enhancement Systems Studies).
4. Work on Stress Inoculation Training (NASA project, Training high stress groups See [Roadmap to Resilience](#) (Meichenbaum, 2012).

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Additional Resources

American Telemedicine Association Telemental Health Special Interest Groups
(www.americantelemed.org). **Evidence-based telehealth interventions**
www.americantelemed.org/files/public/standards/EvidenceBasedTelementalHealth_Withcover.pdf

(Australian Web Portal that evaluates and rates Internet and Mobile Interventions based on level of evidence.

<http://www.beacon.anu.edu.au>

Ohio Psychological Board Telepsychology Guidelines.

www.ohpsych.org/professionalissues.aspx

**IV. TOPICAL PANEL 3 FRIDAY DEC .13 9:20-10:20
CHILDREN AND ADOLESCENTS**

With John Gottman and Mary Pipher

Almost all forms of adult psychopathology have their origins in childhood and adolescence, whether it is "externalizing" problems such as aggression, conduct disorders or "internalizing" problems such as anxiety or depressive disorders. The prevalence of mental disorders among youth worldwide is estimated to be 20%. In the U.S. alone, one-fifth of children, up to 15 million have a diagnosable disorder. Annual treatment costs in the U.S. is estimated to be more than 11 billion dollars.

As Research Director of an Institute designed to prevent the development of psychopathology (see www.melissainstitute.org), I have given five day workshops on this topic. I have taken the liberty of including in this document the Handout I use when presenting on ways to treat children with aggressive behaviors, ways to conduct parent training and address parent-adolescent conflict, as well treat children and adolescents with anxiety and depressive disorders (including suicidality) and PTSD.

**I HOPE THIS HANDOUT IS HELPFUL AND I WELCOME YOUR FEEDBACK
(dhmeich@aol.com).**

**DEVELOPMENTAL PSYCHOPATHOLOGY: A LIFE-SPAN
TREATMENT APPROACH**

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and
Research Director of
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Miami, Florida

(www.melissainstitute.org)
(www.teachsafeschools.org)
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How To Use This Handbook

I WANT TO LEARN MORE ABOUT OR HOW TO:

- | | |
|--|---|
| <p>Conduct APPLICATION TRAINING (p. 341)
 Conduct ASSESSMENT (p. 132)
 Conduct ATTRIBUTION TRAINING (p. 347)
 Formulate CASE CONCEPTUALIZATION MODEL (p. 82)
 Examples: Intimate Partner Violence (p. 108)
 Juvenile Offenders (p. 83)
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 Identify CORE TASKS OF THERAPY (p. 204)
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 Employ GESTALT-BASED ASSESSMENT (p. 178)
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 Examples: Clinical Interviews (p. 150)
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 Use IMAGERY-BASED ASSESSMENT (p. 167)
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 Employ LETTER WRITING/JOURNALING (p. 309)
 How to MAKE A BATTERER (p. 118)
 JUVENILE OFFENDER (p. 54)
 TERRORIST (p. 130)</p> | <p>Examine META-ANALYSES
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 Examine PATIENT HANDOUTS (p. 12)
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 Conduct PROBLEM-SOLVING TRAINING (p. 311)
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THE NATURE OF THE CHALLENGE MENTAL DISORDERS IN CHILDREN AND YOUTH

**(Research findings compiled from Berman et al., 2005; Bongar and Stolberg, 2009;
Kazak et al., 2010; Kelley, et al., 2010)**

It is estimated that 10% to 20% of youth (approximately 15 million children in the U.S.) meet diagnostic criteria for a mental health disorder, and many more are at risk for escalating long-term behavioral and emotional problems.

Among those with a recognized need, only 20% to 30% received specialized mental health care.

Up to 50% of youth in the Child Welfare system have mental health problems.

70% of youth in the Juvenile Justice system have mental health problems.

Latino children are most likely to go without needed mental health care.

Although children comprise 25% of the U.S. population, only one-ninth of health care funding is directed at them.

These mental health problems are disproportionately evident in children younger than five who are most at risk for high rates of maltreatment with accompanying immediate and long-term impairments.

79% of children who died from child abuse and neglect were younger than four years old and the first year of life is the single most dangerous period in a child's life (Victimization rate of 12% per 1000 children in the U.S.).

Poverty with its many accompanying cumulative risk factors have significant impact on developing brain centers and functioning. These risk factors may include child abuse and neglect, severe maternal depression, parental substance abuse, harsh parenting, family and community violence.

Early identification and intervention is critical in the form of infant mental health interventions (See American Psychologist, 2011, 66).

25% to 35% of children who enter school are at risk of failing academically and socially contributing to a high school dropout rate of up to 40%.

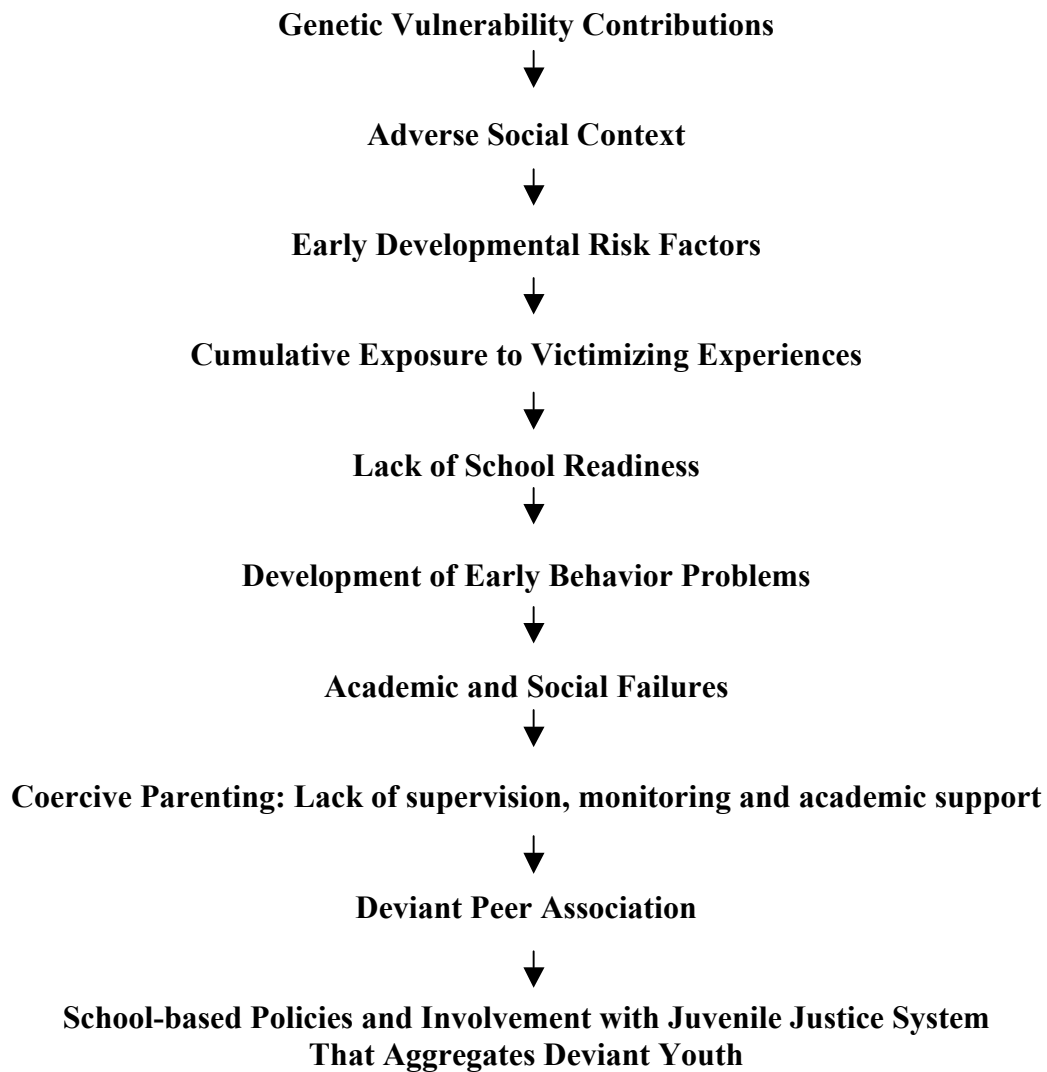
CHILDREN AND YOUTH WITH EXTERNALIZING PROBLEMS

Epidemiological Data

- Up to 5% to 10% of school aged populations evidence clinically significant aggressive behaviors, with boys outnumbering girls approximately 3 to 1.
- Aggressiveness, conduct disorders and anti-social behavior represents the most frequent referral problems to out-patient clinics and account for 30%-50% of these referrals.
- This is most likely an underestimate since many aggressive youths come into contact with the legal system rather than the mental health system.
- Longitudinal studies show that conduct problems and aggression persist in a significant percentage of cases. For example, approximately 45% of school aged children with conduct disorders evidence similar problems 4 years later.
- Childhood and adolescent aggression correlate .63 (.75 corrected for attenuation).
- Keep in mind the 50% rule. Roughly half of children diagnosed with Conduct Disorder will improve over time, no longer showing signs of aggressive or antisocial behavior.
- Nevertheless, aggression that begins early in childhood (early-onset type) is the best predictor of later criminal behavior. 50%-70% of youths arrested in childhood were arrested later as adults.
- Conduct problems often manifest themselves as conflict, threats, bullying, fights, assaults, oppositional-defiant behavior, harmful and disruptive behaviors to others.
- Childhood aggression has emerged as a significant risk factor for subsequent substance abuse, delinquency, school failure, later violence, adult maladjustment, employment difficulties and marital dysfunction.
- Over half the persons who become involved in serious violent offences prior to 27 committed their first violent offence between 17 to 24.
- 75% convicted juvenile offenders are reconvicted between ages 17 to 24.
- Fighting at age 18 correlates with late spouse abuse and with conviction of violent offences by age 32.

A DYNAMIC CASCADE MODEL of the DEVELOPMENT of AGGRESSIVE BEHAVIOR

(As Dodge et al. 2008 observe, each domain in the developmental sequence operates in concert to lead to violent behavior)



A SOCIAL INFORMATION-PROCESSING ANALYSIS

ENCODING PROCESS

- **selectively attend to cues**
- **hypervigilant for hostile cues**
- **failure to attend to relevant neutral and prosocial cues**

REPRESENTATION PROCESS

- **hostile attributional intentional bias (“did it on purpose”)**
- **failure to consider alternative explanations**
- **underperceive own aggression and overperceive others’ responsibility**

RESPONSE SEARCH PROCESS – how to choose goals

- **aggressive responses are most salient in memory**
- **poor ability in generating prosocial verbal assertive solutions**
- **implicit “if-then” rules, choose primarily aggressive goals**

RESPONSE DECISION PROCESS

- **failure to employ consequential thinking**
- **biased outcome estimates**
- **place value and derive satisfaction from aggressive behavior**

RESPONSE SELECTION PROCESS

- **limited experience with non-aggressive responses**
- **preference for direct action aggressive solutions (“get even”)**
- **scheme activation of intentionally elicits “cognitive scripts” that act as learned guides for aggressive responses**

EMOTIONAL VULNERABILITY

high sensitivity - low threshold for emotional reactions and immediate reactions
high reactivity – extreme reactions and high arousal
slow return to baseline – long-lasting reactions

A FUNCTIONAL ANALYSIS OF STUDENT'S AGGRESSIVE BEHAVIOR

1. What form does the aggressive behavior taken? (Reactive-hostile, Instrumental proactive, Relational, or Some Combination of these)?
2. What is the frequency, severity and pervasiveness of the aggressive behavior?
3. Is the aggressive behavior evident in multiple settings? (Pervasiveness)
4. Is the aggressive behavior a long-standing problem or a recent development? (Chronicity - - child or adolescent onset).
5. Is the aggressive behavior the only type of antisocial behavior being exhibited or is the aggression part of a mix that includes defiance of authorities, covert acts of aggression and oppositional behaviors (e.g., stealing, vandalism, fire-setting, teasing animals)?
6. Is aggressive behavior part of a form of deviant and high-risk behavior (substance abuse, risky-behaviors, sexual acting out, bullying behaviors, dating violence)?
7. Does the aggressive behavior occur alone or as part of a group activity (peer association with deviant peers)? Involvement in a gang - - What role? Evidences poor resistance to peer influence?
8. What triggers the aggressive behaviors? Evidences poor impulse control?
9. What factors appear to maintain the aggression? Covert factors such as cognitive processing deficits and styles - - hostile attribution bias, inadequate social problem-solving skills, cognitive distortions? Behavioral and emotional regulation deficits? Sequelae of neuropsychological impairment?
10. Does the child evidence callous, unremorseful reactions, or does he/she evidence prosocial emotions (empathy, regret, guilt, shame, anxiety about consequences)?
11. Are there additional comorbid features such as ADHD, learning disabilities, school failure, depression, peer rejection?
12. What signs of "strengths" and resilience does the child evidence? (Individual competencies, interests, talents, future orientation; Social connectedness, school and church affiliation, mentoring relationships, prosocial peer affiliation; Systematic supports - - availability of supervisory services, health care).
13. Does the child have a sense of belongingness to anyone at school? (Ask the student *"If you were absent from school, who besides his friends, would notice he was absent and would miss him?"* *"If he had a problem at school who would he go to for help?"*)
14. Does the student have prosocial peers and/or a mentor ("Guardian Angel") who he has access to?
15. How does the student see himself? Does he have an inflated self-esteem and is proud of aggressive behavior? Does the student see that he has a "problem" to work on?
16. How supportive is the family? Is the home safe and organized or prone to conflict and chaos?
17. Is there evidence of familial psychopathology (criminality, substance abuse, depression, family conflict and violence, intergenerational aggression)?
18. What is the nature of the stressors that the family experiences (e.g., low SES, minority status, living in "high-risk violent environment?") Are the parents exposed to multiple stressors-current, ecological, familial, developmental?
19. Does the family have access to social supports and services?

- 20. How effective are the parents in performing disciplinary practices, establishing a warm affective bond, monitoring and supervising their child's whereabouts and peer associates?**
- 21. Are the parents involved and supportive of their child's school performance?**
- 22. What cultural supports and strengths does the family have that can be accessed in helping their child (e.g., extended family, church involvement, cultural beliefs)?**
Where indicated, take a weapon's history of at-risk students.

**PROGRAMS AND POLICIES THAT AGGREGATE DEVIANT PEERS AND THAT
SHOULD BE AVOIDED, IF POSSIBLE**

(From Dodge et al. 2006 and www.teachsafeschools.org)

Education

1. Tracking of low-performing students
2. Forced grade retention for disruptive youth
3. Self-contained classrooms for unruly students in special education
4. Group counselling of homogeneously deviant youth
5. Zero tolerance policies for deviant behavior
6. Aggregation of deviant youth through in-school suspension
7. Expulsion practices
8. Alternative schools that aggregate deviant youth
9. Individuals with Disabilities Education Act (IDEA) reforms that allow disruptive special education students to be excluded from mainstream classrooms
10. School-choice policies that leave low-performing students in homogeneous low-performing schools

Juvenile Justice and child welfare

- a. Group incarceration
- b. Military-style boot camps and wilderness challenges (“brat camps”)
- c. Incarceration placement with other offenders who committed the same crime
- d. Custodial residential placement in training schools
- e. Three strikes-mandated long prison terms
- f. Scared Straight
- g. Group counselling by probation officer
- h. Guided group interaction
- i. Positive peer culture
- j. Institutional or group foster care
- k. Bringing younger delinquents together in groups
- l. Vocational training

Mental Health

1. Any group therapy in which the ratio of deviant to non-deviant youth is high
2. Group therapies with poorly trained leaders and lack of supervision
3. Group therapies offering opportunities for unstructured time with deviant peers
4. Group homes or residential facilities that provide inadequate staff training and supervision

Community programming

- Midnight basketball
- Unstructured settings that are unsupervised by authority figures (e.g., youth recreation centers designed as places for teens to “hang out”)
- Group programs at community and recreation centers that are restricted to deviant youth
- After-school programs that serve only or primarily high-risk youth

- **21st Century Community Learning Centers**
- **Interventions that increase the cohesiveness of gangs**
- **Gang Resistance Education and Training programs**
- **Comprehensive Gang Intervention program**
- **Safe Futures program**
- **Urban enterprise zones**
- **Federal housing programs that bring together high-risk families**

**EFFECTIVE PROGRAMS THAT REPRESENT VIABLE ALTERNATIVES TO
AGGREGATING DEVIANT PEERS**

(From Dodge et al. 2006)

Education

1. **Universal, environment-centered programs that focus on school-wide reform, including:**
 - a. **clearly explicated expectations for student and staff behavior**
 - b. **consistent use of proactive school discipline strategies**
 - c. **active monitoring of “hot spots” for behavior problems**
 - d. **improved systems to monitor student achievement and behavior**
2. **Universal classroom programs to build social competence (e.g., Responding in Peaceful and Positive Ways, PATHS, school-wide bullying prevention programs)**
3. **School-wide positive behavior support**
4. **Individual behavior support plan for each student**
5. **Improved training in behavior management practices for classroom teachers, especially:**
 - a. **group contingencies**
 - b. **self-management techniques**
 - c. **differential reinforcement**
6. **Incredible Years Teacher Training**
7. **Good Behavior Game**
8. **Consultation and support for classroom teachers**
9. **Family-based Adolescent Transitions Program**
10. **Matching deviant youth with well-adjusted peers (e.g., Coaching, BrainPower, Peer Coping Skills Training, the Montreal Longitudinal Project)**
11. **Multimodal programs (e.g., LIFT-Linking Interest of Families and Teachers, Fast Track, Seattle Social Development Project)**
12. **Proactive prevention programs that shape student “morals” and encourage responsible decision making**
13. **Cognitive-behavioral Intervention for Trauma in Schools (CBITS)**

Juvenile justice and child welfare

1. **Functional family therapy**
2. **Intensive protective supervision**
3. **Teaching Family Home Model**
4. **Sending delinquent youth to programs that serve the general population of youth in their neighborhoods (e.g., Boys and Girls Clubs)**
5. **Community rather than custodial settings**
6. **Interpersonal skills training**
7. **Individual counselling**
8. **Treatment administered by mental health professionals**
9. **Early diversion programs**
10. **Victim-offender mediation**
11. **Teen court programs**
12. **Therapeutic jurisprudence programs**

13. Community commitment orders

14. Psychiatric consultation

Mental Health

- **Individually administered treatment**
- **Family-based interventions**
- **Adolescent Transitions Program**
- **Linking the Interests of Families and Teachers (LIFT)**
- **Iowa Strengthening Families Program**
- **Family Unidas Program**
- **Mentoring programs such as Big Brothers/Big Sisters**

Community programming

- 1. Public or private organizations that are open to all youth, regardless of risk status, and that provide structure and adult involvement (e.g., religious groups, service clubs, Scouts, Boys and Girls Clubs)**
- 2. School-based extracurricular activities that include pro-social peers**
- 3. Encouragement of commitments outside of gangs (e.g., to jobs, family roles, military service, mentors)**
- 4. Early childhood interventions such as the Perry Preschool Program, school readiness programs like Head Start, and programs that highlight reading comprehension skills**
- 5. Job Corps**
- 6. Policing programs that target high-crime neighborhoods where high-risk youth congregate**
- 7. Community efforts to reduce marginalization of specific groups of youth**

SOME LESSONS LEARNED FROM PREVENTION and TREATMENT INTERVENTION RESEARCH FOR CHILDREN/YOUTH WITH DISRUPTIVE BEHAVIOR DISORDERS (DBD)

When government asks scientists what to do, scientists tend to respond with assurances far beyond the state of science and out-of-keeping with the tentative nature of scientific knowledge. Science requires a “disputatous community of truth-seekers” to keep researchers from falling into the “over-advocacy” trap and “sleight of hand” marketing (Campbell, 1988; Littell, 2006; Mendel, 2000).

1. Any definition of aggression and conduct problems in children and youth need to recognize the heterogeneous nature of the population and tailor assessment prevention and treatment interventions accordingly. Need to draw a distinction between early starters and late-onset aggressive behavioral patterns (see Moffitt, 2003).
2. There are substantial gender differences in the form, pattern and developmental course of boys versus girls, (See Levene et al. 2001; Moffitt et al. 2002; Pepler et al. 2006; Undwerwood, 2003 and Website addresses of Aggression in Girls.) Interventions should be gender-sensitive (OJJDP, 1988; Patton & Morgan, 2002; Levene, 1997; Levene et al. 2001; Walsh et al. 2002). See www.melissainstitute.org for Handout materials on a conference on Gender differences in aggression.
3. There is a need to take into consideration cultural and racial differences in identifying risk and protective factors and in conducting assessment and treatment interventions. The nature of risk and protective factors (role of hopelessness, attitude toward academic achievement, parenting style, responsiveness to different disciplinary efforts, form of treatment and risk factors for dropping out of treatment have been found to vary by ethnic groups. de Arellano (2008) and de Arellano and Danielson (2008) have described an assessment strategy with ethnic minority child populations (Cognitive and Behavioral Practice, 15, 53-66 and Behavior Modification, 29, 130-155.) Kazdin et al. (1995) have discussed risk factors for dropping out of treatment among different racial and ethnic groups. See Gay (2000), Goldston et al. (2008), Hammond and Yung (1993, 1994), Paniagua (1994) for a discussion of cultural considerations.
4. Aggression behavior problems in the elementary school years are significant predictors of later severe problems with antisocial behavior adolescence. There is a critical need for early intervention. The earlier the intervention, the more likely they are to be effective. Intervention efforts are more successful with children between ages 4 to 10 than with older children. Overall, corrective interventions after 10 are not very effective. Aggressive behavior is relatively stable by grade 3, but can be altered. (Frick, 2001, Guerra & Smith, 2006; Kazdin & Weisz, 2003).
5. Identifying “high-risk” children based on a single marker such as externalizing behavior often misidentifies many children and underestimates females. In order to identify the 5% to 10% of school-aged students who evidence clinically significant

- aggressive behaviors (with boys outnumbering girls 3:1), there is a need to use a multi-gating assessment procedure that uses a variety of indicators and sources. Keep in mind the 50% Rule. Roughly half of children diagnosed with Conduct disorder will improve over time, no longer showing signs of aggression or antisocial behavior at adolescence. 50% to 70% of hard-to-manage preschoolers do not persist in problem behaviors past the ages of 6 to 9 (Cavell, 2000). There is a need not to prematurely label a child. When at risk students are identified there is a need to build upon those protective factors that contribute to desistance from aggressive behavior. There is a need to maintain and convey HOPE. (Eron et al., 1994; Green, 1998; Knesting & Waldron, 2006; Smith et al., 2000; Trembley et al., 1995).
6. The factors that place children at risk are multifaceted and are unlikely to be modified by relatively, brief, time-limited interventions. Moreover, single factor-focused interventions are not likely to be successful. There is a need to target multiple risk factors and protective resources. **There is no simple “magic-bullet” solution to violence reduction.** (Chamberlain, 2003; Kazdin, 1994; Sherman et al., 1997).
 7. Programs that segregate and that aggregate antisocial youth do not work and can exacerbate the incidence of aggression and violent behaviors (see Dishion et al., 2006).
 8. One cannot conduct a training program and hope for transfer or generalization or skills maintenance. Trainers need to follow research-based guidelines on how to increase the likelihood of generalization. See the detailed set of guidelines to be followed before, during and after training to increase the likelihood of skills maintenance across settings, across response domains, and over time. Interventions that are conducted across multiple settings and systems (school, home community) are more effective than single setting interactions (Walker et al., 2004).
 9. There is a need to involve prosocial peers as part of the intervention. Interventions that only engage “high-risk” youth may do more harm, and inadvertently increase the rate of antisocial behavior. A prosocial mentor (“Guardian Angel”) who can foster “bondedness” with prosocial peers and institutions is critical to sustainable positive changes. (Dubois and Karcher, 2005). If a training program is going to be effective there is a need to assess and then alter the youth’s peer network. This can be challenging since prosocial peer’s may be responding to the youth’s former social reputation, rather than to the youth’s current level of social functioning. There may be a need to “shop around” for a new peer group tied to the youth’s talents and interests.
 10. While parent management training is one of the most effective interventions with children and youth with Disruptive Behavior Disorders, parents of such children have high drop-out and no show rates. There is a need to focus on engagement procedures using Motivational Interviewing procedures and to systematically assess for possible barriers to participating in treatment at the outset and throughout training (see Brooks & Goldstein, 2001; Cavell, 2000; Kazdin et al., 1998; 2005).

11. Parents alone or even with a partnership with teachers, cannot provide adequate supervision to high-risk children and youth. As the adage goes, “It takes a village”, in the form of involvement and supervision by caring adults outside the family to work and reducing aggressive, antisocial and violent behavior. (See the Website prevnet.ca for an example of how they organized 42 non-governmental community agencies). Consider Pepler and Craig’s (2008) estimate that worldwide “an estimated 200 million children and youth around the world are being abused by their peers” (p. xix). In fact, an international effort is now underway to stop bullying and violence by youth called the Kandersteg Declaration.
12. Treatment programs should attend to the presence of comorbid disorders like hyperactivity, anxiety, depression, suicidal ideation, PTSD, learning disabilities and physical disorders. Psychosocial interventions should be synergistically combined with pharmacological interventions, where indicated. If medication is being prescribed, there is a critical need to monitor and address the issue of treatment nonadherence. When improvement occurs it is important to have the youth and family attribute improvement not only to the medication per se, but what the medication allowed the youth to “do”, namely, “notice, catch, plan, interrupt, choose, control behavior, in spite of provocations, peer pressure, bad moods, etc.” Ensure that the youth “takes credit” and “ownership” for behavior changes. Comprehensive intervention programs that combine teacher classroom management training, small group social-cognitive training, and family-based parent-training interventions like those conducted by the Conduct Problem Prevention Research Group and the Parent Training Programs have proven most effective. (Dodge et al., 2005; Everston & Weinstein, 2006; Kazdin, 2008).
13. There is a need to engage and train primary health care professionals to identify and screen for the mental health needs of the youth they treat. It is estimated that 25% of 150 million child visits per year for primary health care have psychological or behavioral problems associated with the presenting medical complaints. There is a need to train these gatekeepers to become front-line screeners. (*See Melissa Institute Website for Meichenbaum’s discussion on how to train Primary doctors to screen for suicidal ideation in adolescents*).
14. Most successful programs are those that prevent youth from engaging in delinquent behaviors in the first place. Thus, preventative efforts that reduce risk factors and that bolster protective factors are most effective. There is a need to adopt a strengths-based intervention approach and work to bolster student’s and families’ resilience (see Meichenbaum, 2009 and Melissa Institute Website for examples of successful preventative programs). For example, home-based nurse visiting programs that provide prenatal care and ongoing education and support following delivery; parent management training programs; Preschool school readiness intervention programs; school-based cognitive and emotional training programs; bully prevention programs; mentoring programs; community-wide programs that include wrap-around services from multiple agencies such as Communities that Care, Youth Prevention Council and Community Blueprints for Action Programs; and programs that relocate high-risk

families to more supportive affluent and less distressed neighborhoods have each been found to reduce the level of aggressive behaviors and violence. Illustrative promising programs with high-risk children and families have been offered by Dubois and Karcher, 2006; Hawkins and Catalano, 1992; Jaycox et al., 2006; LaGreca et al., 2002, and Stein et al., 2003. Such programs should work to reduce risk factors and bolster protective factors, as enumerated in the following list.

15. See LaRoche & Tawa (2011) for a discussion of ways to empower urban youths to take back the streets. Peace and Conflict, 17, 4-21.
(***martin.Laroche@childrens.harvard.edu***)

LIST OF RISK AND PROTECTIVE FACTORS
(See CDC List www.vetoviolence.org/pop)

RISK FACTORS

Child Risk factors: Disabilities, low IQ and poor verbal-analytic skills, low self-esteem, poor social skills, impulsive behavior, poor emotional self-regulation skills, impulsive behavior, information-processing deficits and a sense of alienation, lack of empathy, difficult temperament, insecure attachment.

Family risk factors: Teenage mother, father absence, large family size, family violence and disharmony, long-term parental unemployment, low involvement in child's academic and social activities, psychiatric/criminal activities, violent models harsh and coercive discipline practices, presence of neglect and abuse.

Life event stressors: Divorce, family breakup, death of family member, dislocation, exposure to ongoing neighborhood violence.

School risk factors: Academic failure, aggregation of deviant peer group, bullying, peer rejection, poor attachment to school, unsupportive and undisciplined school environment (large class size, inexperienced teachers, poor principal leadership), poor emotional climate, high ratio of reprimands to praise, low teacher morale, high turnover, in both students and teachers.

PROTECTIVE FACTORS

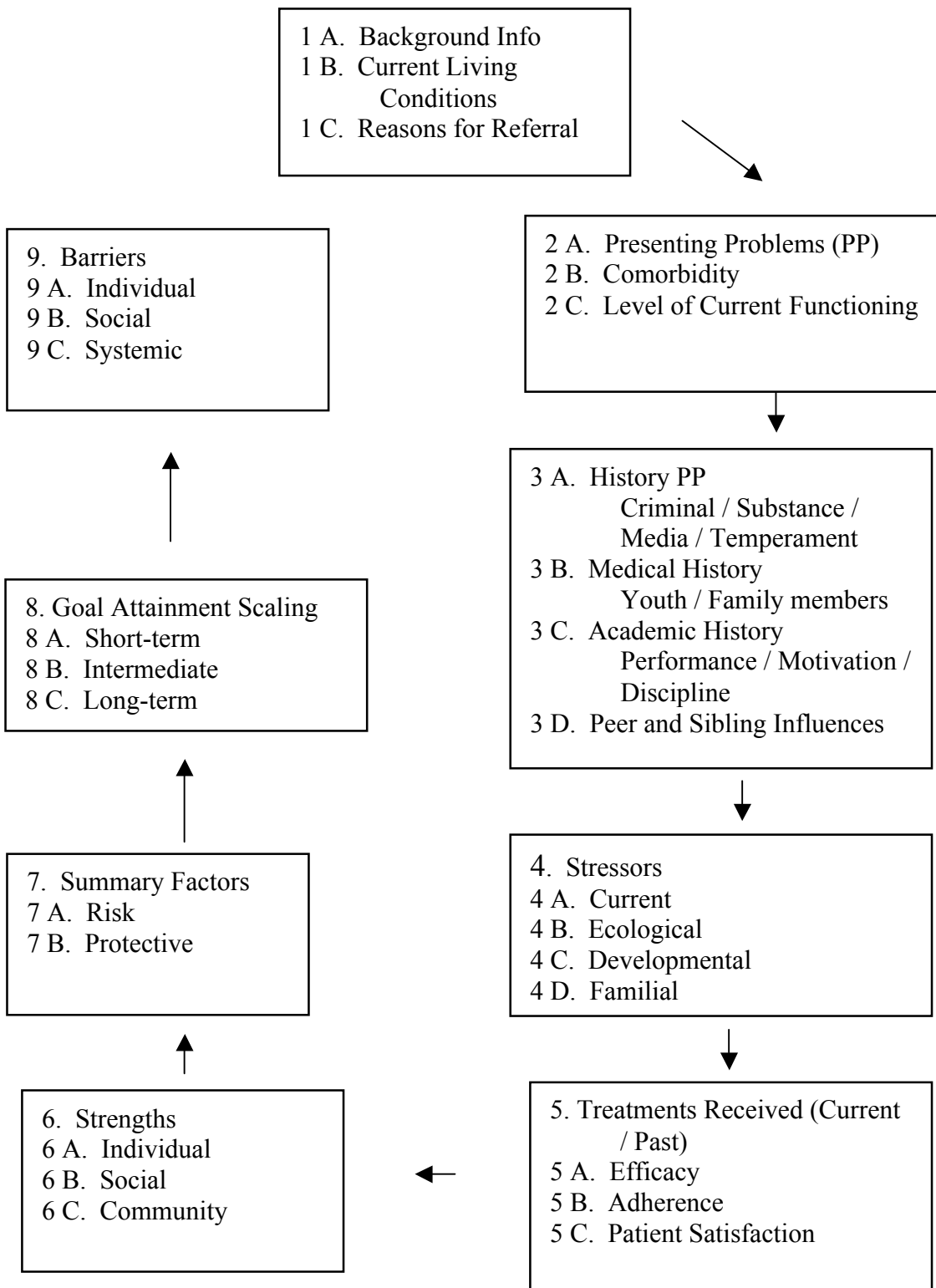
Child protective factors: Social skills and competencies, attachment to family and school, empathy, problem-solving skills, a sense of optimism and future orientation, above average intelligence, easy temperament, school achievement, Internal Locus of Control, good style, bicultural competence, and a sense of humor.

Family protective factors: Supportive caring parents, family harmony, small family size and more than two years between siblings, secure, supportive and stable family, sense of belonging and bonding, family rituals, strong family norms and morality, responsibilities at home (chores).

School protective factors: A positive school climate, prosocial peer group, opportunities for success and recognition of achievement, prosocial norms concerning violence, sense of belonging, high staff morale, adequate staffing, staff development and consultation, Principal leadership and commitment (*See CDC List www.vetoviolence.org/pop*).

Community and cultural protective factors: Access to support services, community prosocial networking, commitment to and participation in community identity and prosocial cultural norms, participation in church or other community groups, ethnic pride, community cultural norms against violence.

CASE CONCEPTUALIZATION MODEL FOR JUVENILE OFFENDERS



**COMPUTER-GENERATED REPORT BASED ON
CASE CONCEPTUALIZATION MODEL (CCM)
OF JUVENILE OFFENDERS**

(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 reasons 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 is also experiencing difficulties with... **(2B – comorbidity)**. These presenting and comorbid problems are having an impact on the level of functioning as evidenced 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 peer and sibling influences such as **(3D)**.

An examination of **current and past stressors** for both the youth and his family members reveal **(4A to 4D)**. [*Note: 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 sources for individual and familial and cultural 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 Scaling (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.)** These goals should be stated in positive terms as behaviors designed to be increased, not stated in negative terms as behaviors designed to be reduced or stopped.

Specific Ways Behavior Should Change

Minimal	Moderate	Significant
Improvement	Improvement	Improvement

0%	25%	50%	75%	100%
change	change	change	change	change

Target Behavior 1

Target Behavior 2

Target Behavior 3

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.)*.

In collaboration with the youth and his family, the following assessment 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).*

The selected treatment interventions should be evidence-based. See the following websites for lists of such evidence-based interventions.

<http://ucoll.fdu.edu/apa/lksinter.html>
<http://www.nationalregistry.samhsa.gov>
<http://www.netsnet.org>

SOCIAL ECOLOGICAL MODEL

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

At the Individual Level

Reduce risk exposure from conception onward

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

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

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

Build on strengths and “islands of competence”.

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

At the Relationship Level

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

Nurture school connectedness.

Provide mentoring programs (“Guardian Angels”).

Encourage association with prosocial peers and positive role models.

At the Community Level

Encourage and reward voluntary community altruistic behaviors.

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

At the Societal Level

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

LEVELS OF INTERVENTION

(See M.R. Shinn & H.M. Walker (Eds.) (2010). Interventions for Achievement and Behavior Problems in a Three Tier Model Including RTI. NASP Publication)

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

- Reduce Risk Factors, especially those tied to poverty.
- Conduct initial screening. See Adverse Childhood Experience Scale (ACE). Assess cumulative exposure to stressors. *(See ACE questionnaire in Handout Section on impact of trauma)*
- Focus on schools as a critical setting. “Report Card” for Principals. Do not implement programs that will exacerbate the situation. *(See Meichenbaum “How to make a violent youth - - www.melissainstitute.org).*
- Improve school climate, school satisfaction, school connectedness and set school-wide behavior and academic expectations. Promote well-being skills.
- Ensure effective academic instruction. (See Meichenbaum & Biemiller Nurturing independent learners. Brookline Books).
- Bolster resilience-enhancing behaviors and violence prevention skills training. Use “ordinary magic” procedures *(See Ann Masten on resilience on www.melissainstitute.org). M.A. Alvord et al. 2011. Resilience builder program for children and adolescents. Research Press).*

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

- Target at-risk students (offspring of “high-risk parents”; High ACE scoring students). For example see Cognitive-behavioral Intervention For Trauma in Schools - - CBITS. *(See Marlene Wong on www.melissainstitute.org).*
- Use adult mentors with frequent monitoring.
- Use peer-based intervention programs.
- Teach self-management skills and executive skills.
- Use scheduling changes and provide other supports.

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

- Provide wrap-around services (family, community).
- Maintain continuity of care across the life-span.
- Provide individual student services.

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

COGNITIVE BEHAVIORAL THERAPEUTIC (CBT) PROCEDURES WITH AGGRESSIVE CHILDREN AND ADOLESCENTS

There are a number of evidence-based programs designed for angry and aggressive children and youth. The Melissa Institute for Violence Prevention has detailed discussions of gender-specific CBT interventions and ways to bolster resilience in high-risk populations. Please see:

www.melissainstitute.org
www.teachsafeschools.org

See the following references:

Dodge, K.A., Dishion, T.J., & Lansford, J.E. (2006). Deviant peer influences in programs for youth. New York: Guilford Press.

Chamberlain, P. (2003). Treating chronic juvenile offenders. Washington, DC: American Psychological Association.

Larson, J., & Lochman, J.E. (2010). Helping school children cope with anger. New York: Guilford Press.

Meichenbaum, D. (2007). Treating individuals with anger-control problems and aggressive behavior. Clearwater, FL: Institute Press.

Weisz, J.R. & Kazdin, A.E. (Eds.). (2010). Evidence-based psychotherapies for children and adolescents. New York: Guilford Press.

COGNITIVE BEHAVIORAL THERAPEUTIC PROCEDURES

- Affective Education (Discuss positive and negative features of anger and situational variability)
- Goal Setting and Self-Monitoring
- Self-Instruction (before, during, after)
- Consequential Thinking
- Self-Calming, such as deep breathing, mindfulness exercises, backward counting
- Assertiveness Training
- Problem-Solving Training (Problem, Possible Solutions, Consequences, Select, Act and Review) (Goal, Plan, Do, Check)
- Behavioral Rehearsal and “Mini-Experiments”
- Behavioral Contracts
- Relapse Prevention Procedures
- Attribution Re-Training

LEARNING TO CONTROL ANGER

Examples of procedures to control anger in adolescents were offered by David Wexler; The adolescent self. New York: W.W. Norton.

Freeze-frame Technique (Wexler, p.79)

1. Identify the supposedly "uncontrollable" behavior.
2. Recall the scene as in a movie, as vividly as possible.
3. Slow time down.
4. Freeze the frame when the "uncontrollable" behavior is about to occur.
5. Scan for physical sensations, emotions and thoughts.
6. Identify the central needs. "What was the need I was trying to fill?"
7. Generate a list of creative options for satisfying the needs.
8. Choose the options that have the highest satisfaction and lowest negative side- effects.
9. Redirect the movie with the new ending and observe the effects, both internal and external.

Positive end-result imagery

1. Identify the reasonable goal behavior.
2. Generate the anticipated future scene as vividly as possible, as in a movie.
3. Freeze the frame when the "uncontrollable" behavior is about to occur.
4. Rehearse the option you have chosen, vividly and successfully.

Elias, M. J., & Clabby, J. F. (1989). Social decision making skills. Rockville, MD: Aspen.

1. Look for signs of different feelings.
2. Tell yourself what the problem is.
3. Decide on your goal.
4. Stop and think of as many solutions to the problem as you can.

5. For each solution, think of all the things that might happen next.
6. Choose your best solution.
7. Plan it and make a final check.
8. Try it and rethink it.

USE THE LANGUAGE OF "CHOICE" AND "CONTROL"

1. We're talking about who is "in charge"
2. Recognize options
3. Have choices
4. Notice, catch, interrupt, monitor
5. Act as own coach, own therapist
6. Read between the lines
7. Defuse the situation
8. Stake out a middle ground
9. Don't give in
10. Don't automatically fall into the same behavioral rut
11. Play a different CD in your head
12. Talk to yourself differently
13. Soothe (relax) yourself. Calm yourself down.
14. Play detective
15. Empower yourself
16. Short-circuited conflict
17. Redirect the situation
18. Don't let someone else dictate (determine) how you feel about what you do
19. Choose not to let someone else get you into trouble ("pull your chimes").
20. Nudge your memory
21. Use what you learned
22. Organize yourself
23. Take charge
24. Take a time out (relax)
25. Seek help
26. Call upon your own personal ally when you need it
27. Talk yourself out of
28. "So many things you know how to do, you just hadn't known that you knew them" (M. Erickson).
29. Do I have your permission to share how you handled this with others I work with? I would not use your name.
30. Use freeze frame technique (see Wexler, 1991)

SOCIAL SKILLS TAUGHT TO ADOLESCENTS

(See Wexler, 1991)

Dealing with conflict situation (Wexler, p. 57)

1. ***Broken Record:*** Keep your listener from slipping away. Shift back to the issue and calmly repeat your point
2. ***Time Out:*** Suggest to the other person that you both wait for a less tense time to discuss the problem. Delay responding until people have calmed down and can be more reasonable.
3. ***State the Importance:*** Clarify how important this is to you and that you don't want to be brushed aside. This often is effective when used with the Broken Record.
4. ***Admitting Past Errors:*** Avoid letting the other person sidetrack you with accusations about the past. Admit that you may have made some errors in the past, but this is now - and you are trying to handle things better.
5. ***Playing Detective:*** Ask sincerely about the other person's specific complaints so you can understand and attempt to solve the problem.

Making request from authority figures (Wexler, p.59)

1. ***The stroke:*** "Thanks for caring about me, mom, I know you must be worried about me."
2. ***The "I" message:*** "I would really like to stay out later tonight for this party."
3. ***The detective:*** "What will it take to get your trust? How can I show you that I'm ready to handle this?"
4. If response is "no," do not disconnect, or shut down. ***Use the broken record:*** "It sounds like you're really not sure whether I can handle this - how can we work this out? How can I earn your trust? If there is still a "No," then it is time to accept the situation, but make sure and get some credit for this: ***The future credit:*** "OK, I can see that you don't think I'm ready for this yet. But, I'd like you to take into consideration how well I've gone along with this the next time something like this comes up. I want you to trust me again."

Name: _____

Date: _____

Class: _____

Page No: _____

PERSONAL PROBLEM SOLVING WORKBOOK

I am feeling

My problem is

My goal is

I am going to stop and think of as many solutions as I can, and think about their consequences.

Solutions I might try:

If I try it, what can happen next?

My plan for solving my problem is that I will

After I tried it and re-checked it, I found that it worked

and next time I might

REPORT CARD ON HOW WELL YOUR TRAINING PROGRAMS FOSTER GENERALIZATION

*How many of these 24 features are included in your training program?
What grade would you give to your Intervention Program in its ability to foster
generalization?*

In order to foster transfer at the OUTSET OF TRAINING, my program:

- Establishes a good working alliance with trainees so the trainer is viewed as a supportive constructive “coach.”
- Uses explicit collaborative goal-setting to nurture hope. Discusses the reasons and value of transfer and relates training tasks to treatment goals.
- Explicitly instructs, challenges and conveys an “expectant attitude” about transfer.
- Uses discovery learning, labelling transfer skills and strategies.
- Solicits trainees' public commitment and uses behavioral contracts.
- Anticipates and discusses possible barriers to transfer.
- Chooses training and transfer tasks carefully (builds in similarities and uses ecologically-valued training tasks).
- Develops a “community of learners” (e.g., advanced trainees, an Alumni Club).

In order to foster transfer DURING TRAINING, my training program:

- Keeps training simple- uses acronyms and reminders (wallet-size cards and a “Hope Chest”).
- Uses performance-based training to the point of mastery. Provides regular feedback and has trainees self-evaluate and record performance.
- Accesses prior knowledge and skills, uses advance organizers and scaffolded instruction.
- Teaches metacognitive skills-involving self-monitoring, planning, self-management, self-rewarding.
- Conducts training across setting, using multiple trainers and environmental supports.
- Uses cognitive modeling, think alouds, journaling, rehearsal and role playing procedures.

- Promotes generalization through between session assignments and between session telephone coaching.
- Includes relapse prevention activities throughout training that decreases the chance of setbacks after training is completed. “Inoculates” against failure.

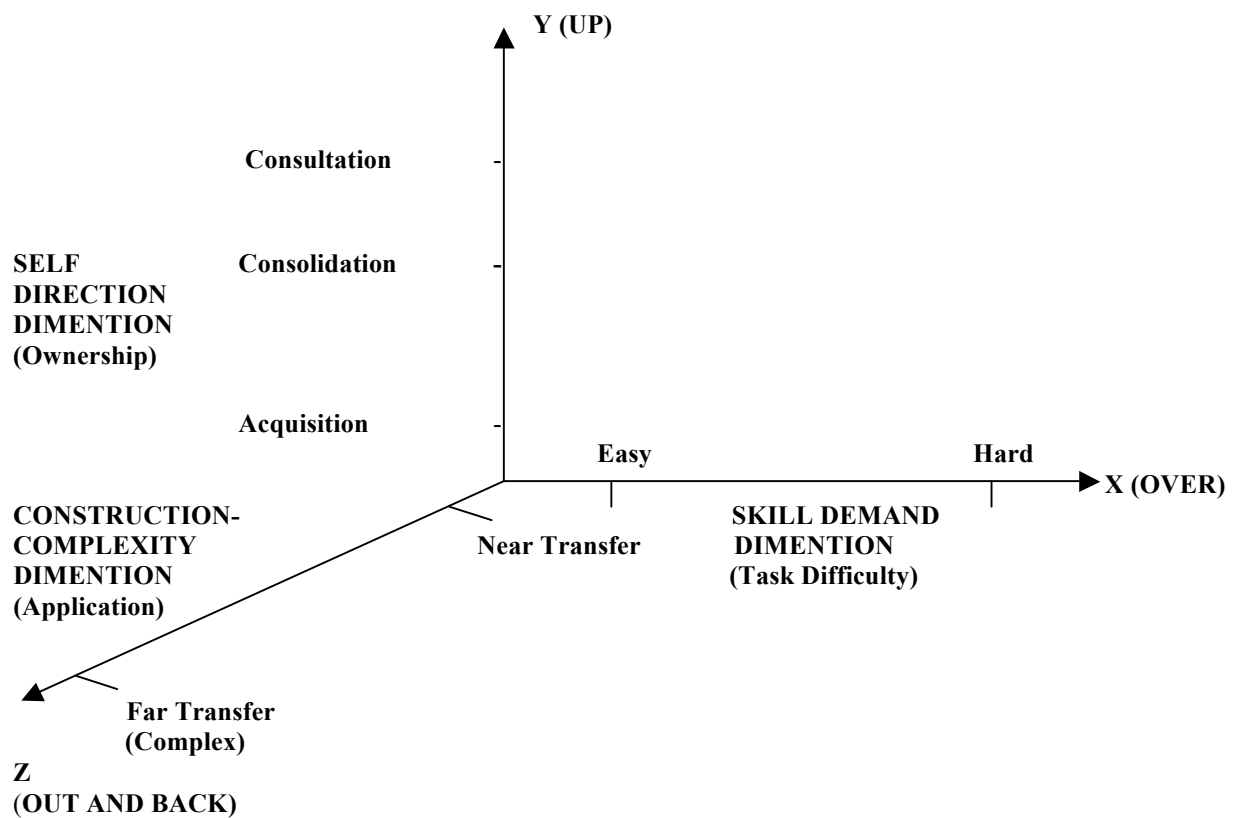
In order to foster transfer at the CONCLUSION, my training program:

- Puts trainees in a consultative role (uses reflection, opportunity to teach others, puts trainees in a position of responsibility).
- Ensures trainees directly benefit and receive reinforcement for using and describing their transfer skills.
- Provides active aftercare supervision-fades supports and “scaffolds” assistance.
- Ensures trainees take credit and ownership for change (self-attributions). Nurtures personal agency.
- Ensures participants design personal transfer activities.
- Involves training significant others and ensures that they support, model and reinforce the trainees' new adaptive skills.
- Provides booster sessions.
- Conducts a graduation ceremony and offers a Certificate of Accomplishment.

GOALS OF INSTRUCTION

- 1) To Teach students how to do more and more difficult tasks;
- 2) To do so on their own as they move from initial acquisition to mastery, even to the point where they can teach others, as well as themselves;
- 3) To apply what they learn with understanding to novel tasks in novel settings.

MODEL OF MASTERY



“SELLING” PREVENTATIVE PROGRAMS: FACTOIDS

1. **Prevalence of Serious Emotional Disturbance 9-17 year olds**
 5%-9% of youth with serious emotional disturbance and extreme functional impairment
 20% of youth with diagnosable disorder
 As many as 3% to 5% of school children are considered to have serious behavioral and emotional disabilities that require intensive coordinated services
Less than 2% of those students receive any Mental Health services
 For youth in the juvenile justice system the picture is even worse where the estimate of the prevalence of emotional disabilities is estimated to be three to five times greater
(Source Mental Health Schools and Families Working Together for All Children any Youth: Toward Shared Agenda www.nasmhpd.org).
2. The need for early intervention is underscored by the longitudinal research that found that aggressive 8 year olds displayed school maladjustment at age 14, problem drinking and lack of occupational alternatives at age 27 and chronic unemployment at age 36 (Bloomquist & Schnell, 2002). But there is hope that this developmental trajectory can be altered.
3. See Weisz et al. (2005) for a summary of evidence-based prevention and treatment programs for troubled youth (*American Psychologist*, 60, 628-648) and www.oslc.org/spr/apa/summaries.html and www.effectivechildtherapy.com
4. On the preventative side, for every dollar invested in treatment of children with conduct disorders and their families, the return is \$7- \$31 in savings across the life-span.
5. For every dollar spent on Early childhood interventions (Visiting Nurse Program, High Scope Perry Point Preschool Program, Headstart), the rate of return are several dollars and in some intervention programs was as high as \$25,000 over the lifespan. (Karoly et al. 1997).
6. Perhaps, most convincing is data on financial savings from a major Prevention Program called **Triple P** that stands for Positive Parenting Program. Triple P provides a 5 multileveled preventative intervention program for parents. This highly touted evidence-based preventative program has recently demonstrated significant benefits (*see www.TripleP-america.com*).
 The various levels of intervention vary from media-based universal parent education to intense group-based interventions for families who require wrap-around services. The Paxis Institute that evaluates Best Practices (www.paxis.org) has developed a **Triple P Prevention Estimator** that yields the level of estimated financial savings for your State as a result of implementing the Triple P program. It provides the Total Lifetime Costs Saved for implementing the Triple P program in terms of Cases of Maltreatment, Out of Home Placements, and Cases of Lifetime Conduct Disorders.
 For example, if you plug in the State of Florida, where the Melissa Institute is located, the following figures emerge for the 1,977,541 children aged 0-9,

	Estimated Number Of Cases	Annual Costs per Child	Dollars Saved Annually
Substantiated Cases Maltreatment	13,605	\$9,184	\$124,948,320
Out of Home Placements	4,746	\$22,000	\$104, 412,000
	Number	Lifetime Costs	Total Lifetime Costs Saved
Cases of Lifetime Conduct Disorders Averted	6170	\$1,400,000	\$8,638,000,000

Given the financial needs of the U.S., such Prevention programs seem like a wise investment.

7. Roughly 30% of all students in the U.S. are not graduating, and up to 58% of Hispanics do not graduate high school.
8. Consider that high school graduates earn an average of \$290,000 more during their lifespan than do high school dropouts and graduates pay \$100,000 more in taxes. It has been estimated that State and local governments lose \$3.1 billion dollars in tax revenue for each one year cohort of high school dropouts. For instance, Clive Belfield and Henry Levin (2007) in their book "The price we pay", estimates that each year California has 120,000 dropouts and over the cost of a lifetime California will lose \$46 billion in taxes or 2.9% of their Gross State Product.
9. Finally, there is a need to highlight "hope". As Reeves (2003) reports in very high poverty schools with a 90% make up of poverty level, 90% minority status, there is a 90% high achievement level (90/90/90schools). Also see Marzano, 2003, Marzano & Pickering 2001, and Meichenbaum & Biemiller, 1998. **School psychologists need to be the "purveyors of hope" and also have the knowledge and skills to transform hope into practice.** (Eron, et al., 1994; Henderson & Milstein, 2007).

COGNITIVE-BEHAVIORAL APPROACH TOWARD UNDERSTANDING PARENT-CHILD INTERACTIONS

A way to analyze the parents' reports of their child's or adolescent's distressing misbehaviors.

The psychotherapist needs to listen in a nonjudgmental and empathetic fashion to the parents' account of their family situation. But at the same time, the therapist needs to have a theoretical framework in mind of the component features of their account. The following description provides a useful heuristic framework for such an analysis.

I. An analysis of an anecdote: Toward a conceptual model for assessment and intervention

The analysis begins with a consideration of the Parents' **Behavioral Repertoire**

- a) Personal and family goals
- b) Behavioral competence to meet their goals- Do the parents evidence a skills deficit or a performance deficit (skills in their repertoire, but factors get in the way of implementation)?
- c) Role of parental expectancies
- d) Knowledge-base (declarative, strategic, conditional – if-then rules)
“What advice can you give to other parents to achieve such goals?”
- e) Role of potential barriers to achieve goals (intra, interpersonal, familial & societal barriers). Use Barrier Scales in assessment.

II. Consider bi-directionality of behavioral incident (Not only do parents affect children, but children affect parents – two-way street)

- a) Ask circular questions to tap the interactive systemic behavioral chain of events. *“You did what and then what happened and then ...?”*
- b) Listen for descriptions of coercive interpersonal cycles and potential barriers to change
- c) Watch for triggers and for sequence patterns. Behavioral interpersonal “scripts”

III. Consider the role of the thoughts and feelings that precede, accompany and follow prototypic stressful family encounters. Attend to the role of cognitive events, cognitive processes and cognitive structures.

- a) **Cognitive Events** – automatic thoughts and images that precede, accompany and follow events, dripping with affect and are “hot cognitions” Characteristic of cognitive events – appear to occur automatically, emotionally-charged, may reflect immediate reactions or convey “old anger” and response to previous triggers. Such thoughts are rarely

questioned. Taken as truthful, God-given assertions! The Primary Appraisal process is one of a personal provocation, threat, personal slight, and this behavior by their child was done “on purpose” – attribution of intentionality. See one’s responses as justified and see self as a “victim.”

Use a phenomenological approach to tap the role of “hot cognitions,” namely use the Art of Questioning (Socratic questioning). Play “Columbo”-like character --ask a lot of “What” and “How” questions. Stay away from “Why” questions. Use imagery reconstruction procedures (use videotalk). Use direct observation in home or in clinic.

- b) **Cognitive Processes** -- styles of thinking, ruminative processes of not letting go, attributions of intentionality (“He did it on purpose”) and mental habits or “mental heuristics” that are emotionally-driven. Emotions act like a “channel selector” for present and past – availability and salient heuristics and confirmatory bias. Attend to the role of cognitive distortions – such as dichotomous thinking, over generalization, selective abstraction. Thoughts become “commandments” -- “Tyranny of shoulds and musts.” Role of personal beliefs that reflect cognitive structures and schemas.

Attend to the role of meta-emotions and meta-cognitions. Personal theory about child’s behaviors and what it will take to change behaviors. Also, attend to meta-cognitions or thoughts about one’s thinking processes. Problem-solving capacity to view perceived threats as problems-to-be-solved. Evidence of executive and emotional regulation skills – empathy, perspective-taking, decentering perceptions, compassion and the like. Revisit issue of parent goals and where these goals come from. (Developmental history and family-of-origin issues.)

- c) **Cognitive Structures** – nature of the personal, familial and cultural schemas and beliefs that “drive” their behaviors. These are the Core Organizing Principles (COPS) and accompanying behavioral, cognitive and emotional “**scripts**” and “**if ... then**” rules.

How to tap cognitive structures?

- i. Pick a prototypic stressful interpersonal event and elicit the “story.”
- ii. Reflect key affective features and then conduct situational analysis – *“Where else did the individual or family experience similar feelings and have similar reactions? How long has this been going on?”* Conduct a developmental analysis. Ask clients, *“What is common, if anything, across these many situations?”* To which the client is likely going to answer, *“I don’t know!”* The therapist can respond: *“I don’t know either. How can we go about finding out? And moreover, how will finding out help you achieve your goals of X?”*

This line of Socratic questioning lays the groundwork for clients to collect data and self-monitor. (See Meichenbaum's Handbook on

Anger-control for a discussion of how to help parents self-monitor.)

Review common themes that characterize cognitive structures that parallel dominant emotions. These may include:

Anger/Aggressive – issues of fairness, equity, justice, “respect,” entitlement, and interpersonal control- ruminate about “getting even.”

Depression/Sadness/Withdrawal – issues of hopelessness, helplessness, fear of possible rejection, preoccupation and rumination about perceived losses, and moreover, things that are not likely to improve or change- Too many obstacles!

Anxiety/Avoidance – issues of loss of personal control and perception of threat – triggers or reminders from the past and fear of future possible threats, low sense of efficacy. Hypervigilant and sense of “looming vulnerability”- role of cognitions in perpetuating chronic difficulties

Note: Client may have mixed emotions and some emotions such as anger may be a secondary emotion, where the primary emotions are feeling humiliated, guilty, embarrassed or disrespected (dissed). Or, the client may become depressed about being anxious.

IV. Putting It All Together

The therapist can reflect to the client or family (“recast their story”) using a **Clock Metaphor** that highlights the interconnections between perceived triggers, primary and secondary emotions and accompanying thoughts, behavioral acts and resultant consequences.

Use a Clock metaphor – “Vicious circle” or “Vicious cycle”

12 o’clock – External and Internal Triggers

3 o’clock – Primary and Secondary Emotions

6 o’clock – Cognitive Events (automatic thoughts, “hot cognitions”); Cognitive processes – (thinking habits and styles of thinking with accompanying meta theories); Cognitive structures (core beliefs, schemas with accompanying if-then rules)

9 o’clock – Behaviors and reciprocal bi-directional consequences from others

Vicious Cycle or Vicious Circle

Use the Clock Metaphor to reframe the client's (families', groups') reactions as consisting of the four interdependent elements of triggers, emotions, cognitions and behaviors. Encourage clients to collect data that this clock process indeed occurs and then collaboratively consider implications for change efforts. See if you can have clients come up with the need to **“Break the cycle.”** *You are at your “therapeutic best” when your clients are one-step ahead of you offering the observations or suggestions that you, the helper, would otherwise offer. Nurture self-efficacy and client participation in treatment.*

In order to assist the client in coming up with the suggestion to **“Break the cycle”**, the psychotherapist can demonstrate the concept of the **Clock Metaphor** by specifying with hand motions the components of 12 o'clock (triggers), 3 o'clock (primary and secondary emotions), 6 o'clock (thinking process), and 9 o'clock (behaviors and resultant consequences). Once the psychotherapist has obtained examples and elaborations from the client (or family members) of each of these component processes, the psychotherapist can place his/her hand at 9 o'clock (on his imaginary clock) and then slowly move his/her hand around to 6 o'clock and say, **“It sounds to me, and correct me if I am wrong, it is just a vicious...?”** (the psychotherapist should not finish the sentence. There is a high likelihood that the client will finish the sentence and say “vicious circle” or “vicious cycle.” If the psychotherapist's hand reaches 6 o'clock and the client has not answered, then the psychotherapist can say “vicious cycle.”

This Clock Metaphor can be used with families, highlighting for them, how they often get caught up in similar bidirectional cycles. **“If they do so, as they describe, then what can be done?”** The implicit assumption is that they need to learn better ways to break such “cycles;” they need to learn to anticipate when these cycles are likely to occur; notice warning signs and nip the cycle in the bud; consider how they now go about breaking such cycles and whether this is the best way to proceed. Thus, the use of the Clock Metaphor lays the ground work for psychotherapeutic interventions.

In addition, the therapist can ask the client **“What he or she does with all of their feelings?”** View the 3 o'clock primary and secondary emotions as “commodities” that one does something with (for example, stuff his/her feelings, let the feelings blow, avoid situations, drink them away). The therapist can then ask the client: **“If he/she does X with his or her feelings, then what is the impact, what is the toll, what is the price he or she (or others) is paying for handling his/her emotions in such a fashion?”** If the client answers, “I don't know,” then the psychotherapist can answer, **“I don't know either, and how can we go about finding out? Moreover, how will finding out help us better figure out how to help you achieve your treatment goals of X, Y and Z (be specific)?”**

Behind each question is a supposition that there is an answer, namely, an impact, a toll, a price that is being paid. The therapist and client can work to discover and/or co-construct such answers.

After having collected such data that supports the Clock Metaphor with multiple examples, the psychotherapist can ask, **“If you (the client) are engaging in a vicious cycle, as you describe, then what can be done?”** The client may answer, “I need to break the cycle,” to which the therapist can reply **“Break the cycle? What did you have in mind? How are you now going about breaking the cycle?”** *Psychotherapy consists of learning and practicing better ways to break the “cycle” that you describe and experience.*

V. Consider Different Ways to Help Clients “Break the Vicious Cycle”

- i) Ask the clients how they have tried to “break the cycle” in the past in order to achieve their goals. How has it worked? Check out the data.
- ii) Also, the psychotherapist and the clients can use the **Clock Metaphor** to address examples of positive behaviors that reflect “signs of resilience.” Together the psychotherapist and clients can consider the implications for change.

Ask the client(s):

“What are the goals of treatment?” “In other words, what do I (the therapist) exactly do for a living? The answer is really quite straightforward. I work with clients like yourself, to find out how things are right now in their lives and how they would like them to be.”

“In order that our current efforts can be informed, I ask clients what have they tried in the past to get what they want; to achieve their goals.”

“What has worked? What has not worked?”

“How could you tell if it was working?”

“How did that make you feel?”

“What things, if any, got in the way of your doing Y?” (Consider intra and interpersonal barriers.)

“If we work together and I hope we do, how will we know if you are making progress? What will change? Who else would notice these changes?” (Nurture collaborative “We” goal-setting.)

“Can you foresee or envision any barriers, obstacles that might get in the way of your working on achieving Y? What can we do to anticipate and to plan for such potential barriers so you do not get blindsided?”

Don’t rush through these questions. They evolve. Note the widespread use of “what” and “how” questions and the use of we. You can also pose to clients the following questions to nurture “internalization” or increase the likelihood that the client(s) will “take your voice with them.” As therapy progresses, the therapist can ask:

“Let me ask you a different question. Do you ever find yourself, out there, in your day-to-day experience, asking yourself the questions that we ask each other right here?”

Note the therapist is modeling and having clients take on a style of thinking.

THE CASE FOR PARENTING TRAINING

(See Cavell, T.A. (2000). Working with parents of aggressive children. Washington, DC: American Psychological Association; Kazdin, A.E. (2005). Parent management training. New York: Oxford University Press.

*“Failure by parents to effectively punish garden variety coercive behaviors sets in motion interaction sequences that are the basis for training in aggression”
(Patterson, 1986, p. 436)*

To illustrate, consider the following findings of the characteristics of parents of aggressive children. Parents of aggressive children tend to:

- Get caught up in **extended coercive interpersonal cycles** that inadvertently and negatively reinforce the child's coercive behaviors (noncompliance, whining, aggression). Parents tend to give into the child and fail to follow through and be consistent.
- Use intermittent, harsh, “explosive” discipline and more chronic “nattering” behaviors (parental nagging of children and the use of critical comments and idle threats).
- Fail to monitor their children's whereabouts and peer associations.
- Fail to nurture affective-bonds. For example, mothers of disruptive children express positive affect toward their children only 30% of the time, whereas mothers of average children express positive affect 80% of the time.
- Be quick to contain overt aggression directed at them by their children, but seem unconcerned about antisocial acts committed by their children outside of the home.
- Have parent-centered goals which are associated with power assertion disciplining techniques. They tend to have hostile attributional biases when considering what causes their children to misbehave.
- Promising treatment of children and adolescents with conduct disorders and serious aggressive and antisocial behavior include multisystemic therapy, multidimensional treatment, foster care, parent management training and functional family therapy.
- Kazdin (2008) reports that moderators of therapeutic change among children diagnosed with conduct disorders include the child's age, reading achievement, severity of dysfunction, parent psychopathology, parent quality of life, parent-child rearing practices and the degree of perceived barriers (e.g., seeing treatment as too demanding, questioning the relevance of treatment).

FACT SHEET ON PARENT TRAINING

- 59% to 70% of parents benefit from parent training, but 30% to 50% fail to maintain clinically significant improvements.
- Parent-adolescent programs have resulted in a 35% improvement rate.
- The mean effect size of parent training is .86 which means that children whose parents participated in parent training were functioning better than 81% children in the control group.
- The younger the child treated, the better the outcome. For example, for younger children (2.5 years to 6.5 years of age) some 63% had favorable outcomes, whereas only 27% of children 6.5 to 12.5 year of age, benefited from parent training.
- There is a high dropout rate from parent training programs. Parents of older children are more likely to drop out from parent training than parents of younger children.
- The more severe the child's problem, the worse the child's outcome.
- Parents often report satisfaction with the parent training program even though their child's presenting problem still persists.
- Parents prefer performance-oriented (skills rehearsal exercises) and group discussion over lecture and written and self-administered videotape formats.
- Treatment benefits have been found to carry over to siblings.
- Establishing a therapeutic alliance with the parents is critical to outcome (e.g., see Cavell, 2000; Patterson & Chamberlain, 1994). Parents need to feel accepted, understood and supported.
- Involving fathers in parent training is critical.
- In order to effectively treat children with externalizing behavior disorders there is a need to conduct various intervention levels involving other systems (e.g., see Henggeler et al., 1997).
- Adjunctive therapeutic procedures may be required (e.g., in addressing marital discord, parental psychopathology).
- There is a need to build in generalization procedures and relapse prevention skills (see Meichenbaum, 2004).
- Home visiting programs are often helpful (see Wasik and Bryant, 2000).

Poor parenting practices are exacerbated when the parents experience the following risk factors.

Risk Factors For Parents

- Low SES- poverty, on public assistance, low level of education of parents
- Single parent status and dense family size
- Social isolation and insularity-low social supports
- High parental stress level-current, ecological, developmental, chronic stressors
- Parental psychopathology-depression, antisocial behavior, substance abuse, intergenerational violence
- Level of high marital discord and presence of familial violence (In 6% of instances of spouse abuse there is also child abuse. This estimate increases to 40% in homes where there is evidence of physical abuse.) (Slep & Heyman, 2001; Slep & O'Leary, 2001).

POSSIBLE PARENT TRAINING FORMAT

- Composition: Around 5 couples
Do not have couples sitting together-distribute, get to know each other.
- Length of sessions: Around 1 ½ hours, approximately 12 sessions
- Setting: Usually held in an informal setting. In a room where there is a lending library, place to make coffee, snacks, chat informally. Not held in mental health clinic. Can use large group meeting and break up into smaller groups, each with a leader.
- Orientation conveyed:
1. One of collaboration
 2. Not therapy, but rather training. Parenting is challenging for everyone.
 3. Convey that parents will be asked to actively participate, initially setting personal goals, sharing experiences, learning from each other.
 4. This is not a lecture about how to parent. Rather “co-author,” “collaborate,” “script intervention” Each group is “unique.”
 5. Begin to understand their perspective. Non-blaming stance. Learn from each other.
 6. Trainer may use self-disclosure, humor, videotapes, cartoons -keep a group scrapbook of cartoons, role plays, a blackboard,

- and flip chart. Record parents' useful ideas.
7. Have a parent as co-leader (volunteer and rotate turns).
Co-leader takes notes; keeps group on track. Start on time; stress active participation; courtesy (one person at a time); confidentiality.

Carolyn Webster Stratton suggests using something like the following pitch to convey a team approach:

“Our job is to work with you, counsel and support parents. We will work together. Expect parents to be the co-trainers and we always learn. We will put our heads together to come up with better strategies. We each have contributions to offer. We can find out how things are going, how we would like them to be, and what we can do to make them the way we want. As a leader, I can help by offering more alternatives, provide information, and resources. Each of you can offer help deciding and implementing strategies.”

Theme: The theme of the message is to convey a problem-solving stance that will focus on metacognitive verbs (“notice, catch, interrupt, catch self, have choices, game plan, check it out, monitor, stop self, stand back, think about goals, freeze frame, learn from mistakes, pat oneself on the back”).

Initial questions: See attached list of questions. Also use high Expressed Emotion questions allowing a 5 minute answer alone from each parent beforehand.

“I'd like to have your thoughts about your child.”

“Tell me what kind of person he/she is and how you get along.”

Make sure that the initial session does not turn into a “feeding frenzy.” Also focus on positive aspects and strengths. In a subsequent session, ask parents to bring a picture album so the group can get the “full story.”

Normalize reactions: “Indeed things don't seem happy, but all children present challenges. All children have behavior problems from time to time. All parents lose their cool with their kids at time. No one is perfect.

Go back to family of origin- ask about parenting experience.

Talk about pattern of stressors- Note attached “II CE HOPE” acronym for pattern of stressors. (See below for a description of stressors- **II CE HOPE**)

Assess and talk about coping and social supports.

Use relapse prevention model- “Blew it” is occasion to learn. First step.

Trainer should help parents by using the following:

Help parents identify feelings and empathize with their reactions: “It is very frustrating, very upsetting.”

Provide supporting and reinforcing statements about the parents' coping efforts: “By noticing when you become upset,...by noticing the high risk situations,... coercive cycles,...behavioral traps...you can begin to break the vicious cycle. You can begin to learn how to anticipate and identify high risk situations, to notice, to catch, etc...” **Use Clock Metaphor** of 12 o'clock referring to internal/external triggers; 3 o'clock referring to primary/secondary emotions; 6 o'clock referring to automatic thoughts, thinking processes and beliefs; 9 o'clock referring to specific behaviors and resultant consequences.

With groups of parents or families, the Clock Metaphor could be used on a group basis. The trainer can say, “So what triggers it for you is...” “And what sets it off for you is...” The trainer can solicit examples of triggers from each participant, and then move to 3 o'clock examples of feelings. In turn, 6 o'clock and 9 o'clock examples can be solicited, so the group can come to see how the “vicious behavioral cycle” develops and is maintained. How are they each now trying to break the cycle? What are better (more effective and adaptive) ways to break the cycle?

Encourage parents to self-interrogate and to engage in a “freeze frame” response, stopping the action and asking themselves, “What is my goal?” “What is the problem?” and then to engage in problem-solving steps.

Use cue reminders, group role play, humor, “blow up technique,” analogy and metaphors, parenting skills training, and booster sessions.

Have group discuss impact of stress on relating and on parenting.

Parent training may have to be supplemented with individual and couple work.

**WHAT KIND OF SITUATIONS MAKE PARENTS ANGRY
CODING PROVOCATIONS**

II**CE****HOPE**

Interruption of planned activities and obstacles to goal-directed behaviors-the closer someone is to the achievement of his/her goal, the greater the frustration and anger when interrupted

Implications of noncompliance (possible short and long-term consequences of the significant other not complying)-e.g., not only what others do, but the implications for the future as in the case of child/adolescent engaging in unhealthy and risky behaviors

Concern about possible injury to others or to self and possible concern of what might have happened (e.g., engaging in high-risk behaviors)

Expectations violated-disruption of the flow of interpersonal interactions by breaking implicit shared rules. Something that significant other “should” or “should not” be doing that elicits anger

History repeats itself (over and over again)-pattern of annoying behaviors that can accumulate over time

Overload of the individual-fatigue or stress can lessen the tolerance level of the child's/adolescent's behavior (i.e., it takes less to get someone angry-“straw that breaks the camel's back”)

Personal peeve (violation of personal rules and values)-e.g., being “dissed” or disrespected in front of others

Embarrassment (noncompliant behavior occurs in public places in front of others)

FACTORS THAT INTERFERE WITH AUTHORITATIVE PARENTING STYLE

Developmental and Contextual Factors

- Family of origin – Intergenerational parenting style
- Exposure to major life events or chronic difficulties (marital discord, divorce, poverty, victimization, psychopathology or illness of family members)
- Community influence – level of authoritative parenting in neighborhood, ecological indicators
 - I. Proximal Factors
- Day-to-day conflicts over mundane issues prove to be significant sources of distress, especially for parents.
- Parents and adolescents have different sets of expectation and ideas about social conventions (namely, how noncompliance issues are framed and defined). Parents often see noncompliance as involving codes of “right/wrong,” or as an expression of “defiance,” while teenagers see this as “matters of personal choice.”
- Parents’ goals, appraisals, attributions of intentionality, mood regulation, emphatic perspective-taking and accompanying flexible actions each influence family interactions.
- Parents (less so than adolescents) tend to walk away from conflictual interactions upset and stay upset longer.
- Such conflicts can take a toll (especially on mothers who bear the burden of “front-line action”). (Increased anxiety, depression, lowered self-esteem, diminished life-satisfaction and marital dissatisfaction.)
- Mothers and fathers are in agreement about 75% of the time, but such consistency may be more important when children are younger than in adolescence. Critical to have at least one parent who is authoritative.
- Peers can undermine parental influence. For example, adolescents benefit from having friends whose parents are authoritative. Adolescents influenced by social network – company they keep (e.g., peer group can undermine the benefits of parental involvement for academic achievement and peer group can nurture antisocial and substance abusing behaviors.) See Dodge et al. (2006). Deviant peer influences in progress for youth. (Guilford Press)
- Peers should be considered the “final common pathway” to behavior change.

FACT SHEET ABOUT PARENT ADOLESCENT CONFLICT

(See A. Robin & S. Foster, *Negotiating Parent-adolescent conflict*. New York: Guilford Press and R. Barkley & A. Robin (2008) *Your defiant teen* Guilford Press)

- 75% of adolescents report having happy and pleasant relationships with their parents.
- Remaining 25% of families had histories of family difficulties that preceded their children's entry into adolescence. (*Little evidence for adolescent "storm and stress" model of adolescence.*)
- Adolescent mental health was found to be better in families with close, nonconflictual, parent-child relationships.
- An authoritative parenting style where parents are warm, involved, but firm and consistent in establishing and enforcing guidelines, limits, developmentally appropriate expectations, who nurture psychological autonomy leads to more favorable outcomes. Adolescents from authoritative homes achieve more in school, report less depression and anxiety, are more self-reliant and have higher self-esteem, and are less likely to engage in antisocial behaviors.
- According to Steinberg (2001), authoritative parenting works because:
 - a) it makes the child/adolescent more receptive to parental influence;
 - b) it enables more effective and efficient socialization;
 - c) the combination of support and structure facilitates the development of self-regulating skills, cognitive and social skills, and empathy training. (*Note it is not just what parents do, but how they do it that is critical.*)
- Authoritative parenting style can be contrasted with permissive, authoritarian or neglectful styles. Parenting style is an emotional context and is more important than specific parenting practices. (*See Cavell, 2001; Grusec et al., 2000*)
- The benefits of authoritative parenting style hold up across diverse ethnic and socioeconomic groups. When an authoritarian parenting style is experienced, African American adolescents and to a lesser extent Asian American teenagers are less negatively affected than are Caucasian adolescents.

CORE TASKS OF TREATMENT FOR PARENT-ADOLESCENT CONFLICT

1) ESTABLISH A THERAPEUTIC ALLIANCE

- Engagement process (nonjudgmental, understanding, supportive, collaborative, mutually respectful)
- Hear their stories – Discuss parents’ personal stressors
- Conduct a functional assessment and collect information for a Case Conceptualization
- Include a consideration of “strengths” and an examination of “what they hope to achieve”
- Use motivational interviewing procedures (Elicit problem recognition, concerns, intention to change and sense of optimism.)
- Describe the assessment and therapy process and solicit commitments. Address potential barriers to treatment. Use “Columbo” style – lead rather than “tell.” Before providing the treatment rationale, be sure to tap each of the family member's implicit theories about what is causing the family distress and their theories of what is needed to bring about sustainable changes. Tailor treatment rationale to their theories.

2) EDUCATION (AN ONGOING PROCESS)

- Assessment procedures (Interviewing – both individual and together; self-report measures, self-monitoring, direct observation). For example, use Conflict Behavior Questionnaire, Issues Checklist, Parent-Teen Conflict Tactics Scale, Beliefs Questionnaire (*see Barkley & Robin, 2008; Barkley et al., 2001 and Robin & Foster, 1989 for references*). Assess for comorbidity and mediational and moderating factors. Provide feedback on testing results.
- Use Case Conceptualization Model and consider implications for change. Highlight strengths and signs of resilience that family has evidenced.
- Consider family of origin issues in parent's families. What they recall about their adolescent years.
- Provide normative information and nature of “coercive cycles.” Use clock metaphor – vicious cycle and how this can be broken. (12 o'clock are external and internal triggers, 3 o'clock are primary and secondary emotions, 6 o'clock are cognitive events, processes and structures, and 9 o'clock are behavioral acts and resultant consequences). Highlight role of noncompliance and coercive cycles.
- Provide normative information about the myths concerning adolescence so-called “storm and stress” period; and research in developing brain of adolescence and expectations about adolescent judgment processes, peer influences
- Tie in psychotherapeutic tasks and goals of treatment (e.g., skills training, practice “homework”, relapse prevention efforts, need for possible booster sessions).
- Educate about parental stressors – **II CE HOPE**. Use inductive queries, not didactic lecturing approach.
- Use intermittent summaries
- Include education throughout in terms of relapse prevention and follow-through

3) NURTURE HOPE

- Establish collaborative goal-setting (short-term, intermediate and long-term). Use Goal Attainment Scaling Procedures. The psychotherapist can ask each family member:

“How would we know if we were making progress in therapy? What would change? What would others notice?”

Goal-directed thinking has been equated with nurturing hope.

- Highlight and build upon individual and family “strengths”
- Give examples of others’ improvement (group work, alumni club)

4) TEACH AND NURTURE SKILLS

- Discuss present and past efforts to avoid and resolve conflict. Assess house rules and noncompliance episodes.
- Engage parents and teens in problem-solving steps of problem definition, brainstorming possible solutions, negotiation, decision-making about a solution and implementation of the solution (Goal, Plan, Do, Check). Use problem-solving type questions.
- Help parents and teens to develop more effective communication skills while discussing family conflict such as speaking in an even tone of voice, paraphrasing others’ concerns before speaking, providing approval to others for positive communication and avoiding insults, put-downs, ultimatums, and other communication skills (“I” statements, instead of “You” statements)
- Teach parents communication strategies on how to defuse adolescent anger by using a problem-solving discourse. See website www.teachsafeschools.org for a detailed script of the ways to communicate more effectively.
- Also see Video series Every Parent's Guide to Teenagers with Dr. Matt Sanders www.tripleP.org
- Use cognitive restructuring procedures
 - Examine the nature and impact of rigid beliefs; become aware and alter distorted cognitions
 - Help nurture a different narrative that fosters autonomy and responsibility
- Foster parental behaviors
 - Authoritative parenting – supervision, involvement with school, peers, “niche-picking.”
- Increase family positive time and parent positive reinforcement (*See Cavell, 2000*). Use “language of becoming” and modeling of metacognitive processes (namely, the use of active transitive verbs of “notice, catch, interrupt, plan, choose”).
- Teach and encourage parents to selectively attend and reference positive behavior, (ratio of at least 4 positive to every negative)
- Improve deliverance of requests
- Negotiate conflicts and focus on solution-specific disputes
- Use behavioral rehearsal and in vivo practice
- Ensure parent monitoring (“niche picking” and peer contacts)

6) BUILD IN GENERALIZATION PROCEDURES

- See Guidelines designed to enhance treatment generalization
- Use ecologically-based interventions (*See Henggeler et al., 1998*)

7) SELF-ATTRIBUTION TRAINING

- Make sure all family members “take credit for change.”
- (See questions designed to ensure self-attribution)
- Use group feedback

8) RELAPSE PREVENTION PROCEDURES

- Anticipate high-risk situations and ways to plan for “lapse” episodes so they do not become relapses.
- Build in follow-through and booster sessions

9) BUILD IN EVALUATION

- Use Goal Attainment Scaling Procedures (**GAS**)
- Include Patient Satisfaction measures and use Treatment Checklists

ILLUSTRATIVE SKILLS TAUGHT TO FAMILY MEMBERS IN THERAPY TO REDUCE PARENT-ADOLESCENT CONFLICT

Educate about teen misbehavior and the nature of conflict.

Teach to recognize and deal with unreasonable beliefs and expectations.

Improve listening and attending skills.

Improve deliverance of requests, commands, transitional warnings.

Teach authoritative parenting skills (warmth, involvement, firmness, consistency, nurturing adolescent independence).

Improve communication, problem-solving, negotiate solution skills.

Instruct how to “notice, catch, interrupt, and alter” coercive interactions.

Establish behavioral contracts.

Nurture effective discipline strategies.

Educate about monitoring and supervising adolescents.

Instruct how to appropriately praise.

Increase parent involvement in adolescent's school and after-school activities and peer associations.

Improve social supports.

Support parent's sense of acceptance.

INTAKE INTERVIEW WITH FAMILY

Presenting Problem: (McMaster Family Assessment Device - Bishop and Epstein, 1980)

Identification

What do you see the problem to be?

Who first noticed that?

How did you see the problem?

What difficulties were there?

Are you the one who usually notices such things?

Who else does?

Ask each member of the family how he/she sees the problem?

Communication of Problem

Who did you tell about it?

Is that who you would usually tell?

When did you do that?

Is that the way the rest of you see it?

Did anyone else notice that but not tell anyone?

Development of Alternatives

What did you think of doing about it then?

Were there any other alternatives you thought of at that time?

Decisions and Actions

How did you decide what to do?

Who decided?

Is that the way it usually happens?

What did you expect from the different alternatives?

Who usually checks to see that things get done after you have decided?

Evaluation

How do you think you did with that difficulty? (Therapist should indicate which difficulty.)

Do you usually ask yourself that, and go over how you did?

Who do you go over it with?

Is this the way you usually handle family problems? ... What is the same? ... What is different?

What other areas as a family do you feel create problems?

Are there problems that make it hard for the family to function well?

Roles:

Allocation

How do you decide who does what about the house?

Do you talk about it?

Would you like the decision about who handles such jobs handled differently?

Are some people doing jobs they should not do?

What is it about the jobs and the people that makes you think that?

What do you do if the job is not done?

Nurturance and Support

Who do most of you go to when you need someone to talk to? (when someone is upset)? (when the children get upset)?

Educational Help

Who usually oversees what is happening with the children's education?

Who usually helps the kids with school work?

Decision Maker

Who is involved in making major decisions?

Who has the final say?

Who handles the disciplining of the children?

How do you do that?

Tap Emotional Response to Discussion of Situation

What was your response to that?

What did that do to you inside?

How did you feel then?

Did you feel anything else?

Was that all you felt? ... What did you feel besides that?

Do the rest of you feel that way at times like that? Was it similar? Was it different?

Are there feelings that members of the family "hold in" (refrain) from expressing?

Which feelings do you feel you express too little?

Do people in this family talk much with each other?

Who does most of the talking?

Do they feel they can tell things freely to various other members of the family or do they have to qualify or be guarded in their comments?

How do you let the other members of the family know when you are feeling good about them (or feeling very positive about them)?

How can you tell how X feels about that?

How does X let you know that?

How do you check out the message?

Who cares about what is important to you?

Behavioral Control

All families have rules. They also have ways of handling situations. What are some of the family rules? In which areas are the rules most important in your family?

Is the rule the same for everyone - Mom, Dad, each of the children - or does it vary for them individually? Can you discuss the rules?

How are the rules enforced? Is it always that way? Who enforces the rules? Do you all agree that is the way it should be?

Sometimes there are family rules (secrets) that shall not be spoken about. Are there any family rules that are supposed to be kept secret and not spoken about?

QUESTIONS CONCERNING DISCIPLINE

(Cunningham, 1990)

Tell us how spanking (yelling, sending your child to his/her room, etc.) works for you?

How often do you use it?

How does your child feel about it?

How does it affect your relationship with your child? With your other children? With your spouse?

Do you ever feel you loose control when you spank?

What do you see as the advantages of spanking? ... Disadvantages?

Did your parents use spanking?

What effect did it have on your relationship with your parents?

How did you feel about getting spanked?

What did you think?

What do you usually find helps you keep control of your anger?

How would you replay that situation another time if it happens again? What may get in the way of your doing that?

How do you support each other?

What lessons were you teaching?

If you used this approach (cite specific examples) consistently for the next several years what differences might you expect?

What are you telling (showing) your child (cite name) by doing X?

It sounds like this makes sense with the children. Does it apply to adults?

GENERALIZATION

For what other child problems could you apply this strategy? Where else?

Do you think that was the best way to handle the situation?

How would you feel if your child did that?

Now what should he/she do?

How are you going to keep going when the program is finished?

How will you keep yourself reinforced for following the program?

FEEDBACK COUPLE

(Cunningham, 1990)

You have been giving each other a lot of positive feedback in this session. Why does this make sense for you?

How will this affect the management of your son/daughter?

What are you really telling your husband/wife/family when you take the time to sit down together and discuss problems?

If you both consistently solved problems as a couple over the years, what difference would it make for your family?

Is it worth the time and effort for you to X?

What is it like to hear that from your husband/wife?

It sounds like, and correct me if I am wrong, that it is important to balance time between the children. Are there other areas of your life where it is important to maintain a balance?

HOMEWORK
(Webster-Stratton)

What might make it hard for you to do this assignment?

Have you dealt with (or overcome) this problem in the past?

What advice would you offer someone else who has this problem?

Do you think it is as hard for your child to learn to change as it is for you to change?

What can you do to make it easier for you to complete this assignment this week?

Do you think there is another assignment that might be more useful for you?

Have you had any further thoughts about what we talked about last time?

What difficulties did you find with the assignment?

What seems to get in the way of your doing X (assignment)?

What thoughts come to mind when you think about this assignment?

What might make it hard to do?

Does doing this assignment (be specific) seem relevant to your life?

How could we make this assignment more helpful?

Can anyone in the group think of a way that might help her try this assignment?

PARENT SKILLS

Planned Ignoring

Transitional Strategies

Planning Ahead

Publicly Reward

Plan for Visitor

Noncompliance Episodes

Balance Needs Parent and Child

Develop Social Supports

MNEMONICS FOR PROBLEM SOLVING

P -- Pick a solvable problem

A -- Generate Alternative solutions

S -- Select best alternatives

T -- Try it out

E -- Evaluate outcome

(Cuningham, 1990)

S -- State your problem

O -- Outline the problem and your response

L -- List your alternatives

V -- View the consequences of each alternative

E -- Evaluate the outcome of your decision

(Spaccarelli, 1992)

TREATMENT of CHILDREN and YOUTH WITH ANXIETY DISORDERS
(See T. Davis et al. (2011). Evidence-based treatment of anxiety and phobia in children and youth. Clinical Psychology Review, 31, 592-603 and Coping Cat programs by P. Kendall and group interventions with family involvement in Weisz and Kazdin, 2010)

These intervention programs focus on the 10% to 20% of children and youth who experience anxiety disorders. They include experiential activities, workbooks and the learning of self-regulatory skills. They use mnemonics such as Kendall's four-step **FEAR** plan. (Feel frightened, Expect bad things to happen? Attitudes and Actions that might help; Results and Rewards). Generalization steps are built in by having clients use **STIC** activities (Show That I Can activities) and by involving parents. Wendy Silverman and her colleagues have developed an effective Cognitive-behavioral interventions for youth with anxiety disorders. The treatment program includes:

1. Use of self-control, cognitive restructuring and problem-solving procedures. Train to become "**thought detectives.**"
 - a) Learn to use self-control procedures. For example, Silverman and Kurtines (1996) teach anxious youth to use a **STOP** procedure.

S Recognize when you are **scared**, anxious, worried, nervous, afraid

T Ask yourself, "What are my **thoughts**?"; "What am I thinking?"

O "What are **other** thoughts or things I can do?"

P **Praise** myself for working to control my fear and anxiety

In this way, youth can learn to engage in **non-negative thinking** (not use negative coping). Use log sheets of positive self-statements. Also see Kendall et al., 1992; Kendall, 1988, 1990 for examples of how to teach self-control skills using workbooks, videotape vignettes, self-monitoring, self-instructional procedures ("changing one's tune"), and group behavioral rehearsal, role playing, and graded in vivo exposure. These activities are tailored to the child's age level (see Friedberg et al., 2000). For example, children may make a thought-feeling watch with the 12, 3, 6 and 9 o'clock corresponding to "mad, sad, worried and happy." Children are taught how to express their feelings in words and how to write down what went through their mind. "Like the time on a watch, one's feelings also change." Help children understand how feelings and behavior influence social relationships and affect others. Can use **mutual-story telling** as a way to foster understanding.

- b) Correct maladaptive depressive cognitions (dichotomous thinking, catastrophizing, selective abstraction, etc.). Have children learn how to "catch" and "change their tune." How to become a "thought detective"

- c) *“What is the evidence?”*
”Any other explanations?”
”What is another way to look at it?”
(“No one likes me.” “I feel terrible all day.” “I would be completely lost if I didn’t have someone special.”)
”What if?”
 Perform personal experiments and consider data as “evidence” to unfreeze beliefs. Teach youth how to use **thought-testing techniques, behavioral experimentation** and acceptance procedures.
 - d) Address unrealistic expectations and perfectionistic standards (See Stark et al., 1991 – My Standards Questionnaire)
 - e) Use problem-solving approaches – Goal, Plan, Do, Check
 - f) Use role-play vignettes (e.g., rejection by peers, failure, guilt)
2. Intervene for Comorbid Disorders (Anxiety, Anger Substance Abuse)
 3. Monitor gains and build-in self-attributions
 4. Involve Significant Others (Parents, peers, school personnel)
 - a) Educate parents about the nature of depression and treatment
 - b) Improve parent practices
 - c) Improve communication, conflict management and negotiation skills, and promote positive experiences in the family (recreational planning)
(“When X feels Y, what gets in the way of your being a resource to him/her?”)
 - d) Address marital discord
 - e) Address parental psychopathology
 - f) Have child patients teach parents skills learned (Consultative mode)
 5. Build-in relapse prevention that anticipates possible problems, include booster sessions and telephone follow-up. **Following recovery from depression, children often continue to show significant impairment.**

TREATMENT OF CHILDREN AND YOUTH WITH DEPRESSION AND SUICIDAL BEHAVIORS

THE NATURE OF THE CHALLENGE MENTAL DISORDERS IN CHILDREN AND YOUTH

(See Brent, D.A., Poling, K.D. & Goldstein, T.R. (2011). Treating depressed and suicidal adolescents: A clinician's guide. New York: Guilford Press.; Miller, D.N. (2011). Child and adolescent suicidal behavior: School-based prevention, assessment and intervention. New York: Guilford Press; Paul Rohde, Adolescent Coping with Depression Course (www.ABSPress.com). APA videos by David Jobes on ways to treat Adolescent Boys and Girls who are Suicidal.

It is estimated that 10% to 20% of youth (approximately 15 million children in the U.S.) meet diagnostic criteria for a mental health disorder, and many more are at risk for escalating long-term behavioral and emotional problems.

Among those with a recognized need, only 20% to 30% received specialized mental health care.

Up to 50% of youth in the Child Welfare system have mental health problems.

70% of youth in the Juvenile Justice system have mental health problems.

Latino children are most likely to go without needed mental health care.

Although children comprise 25% of the U.S. population, only one-ninth of health care funding is directed at them.

Now let's consider some epidemiological data relevant to child and adolescent depression and suicide. As McLeod et al. (2007, p. 987) observed:

“Depression in childhood and adolescence is a significant, persistent and debilitating problem, undermining social and school functioning, and prompting substantial mental health service use. By age 18, nearly a fourth of all children will have experienced clinically significant depressive symptoms, making such symptoms among the most prevalent psychiatric problems of young people. Once they appear, depressive symptoms remain present and problematic for many youngsters throughout childhood, adolescence and beyond.”

EPIDEMIOLOGICAL STUDIES of ADOLESCENT DEPRESSION

(Research findings compiled from Birmaher et al., 2007; Brent et al., 2011; Merrell, 2008; Miller, 2011; Wasserman & Wasserman, 2009).

- Around one in five adolescents will experience at least one depressive episode before adulthood.
- 12 month prevalence rate exceeds 6% for major depressive disorder (MDD) and 10% for dysthymic disorder in youth.
- The point prevalence for MDD alone has been estimated at 3-8%.
- By age 18, nearly 25% of all youth in the U.S. will have experienced depressive disorder. (Zalsman et al. 2006)
- Prevalence of Dysphoric Disorder (DD) begins earlier and lasts longer than Major Depressive Disorder (MDD). .6-1.7% school children, 1.6%-8% adolescents. DD increases the risk of developing MDD.
- The average age of onset of MDD is around 13 years. One third of those youth with MDD which occur around age 16 have had previous episodes of depression.
- MDD in childhood tends to have an acute onset that lasts an average of 7 to 11 months. 80%-90% of youth will recover from this index episode. Recovery usually takes 11 months. The remaining 10%-20% will have persistent depression that can last longer than 18 months.
- 40% of youth with MDD will have a remission within 2 years; 70% within 5 years. Each recurrence increases the likelihood of future depressive episodes.
- Some 6% to 10% will have protracted depression that will persist into adulthood. The earlier the onset of depression, the more likely it is to persist into adulthood and more likely to recur and be associated with social handicaps.
- MDD increases the risk of developing bipolar depressive disorder (BPD). 20% - 40% of MDD adolescents develop BPD within 5 years. There is a need to assess for parental history of bipolar disorder since it increases their offspring's risk more than tenfold.
- MDD precedes the onset of Substance Abuse Disorders (SUDs) by 4 to 5 years. 15% of those with MDD will go on to develop SUDs, while 20% with MDD will go on to develop a secondary anxiety disorder.
- Youth with DD & MDD are most at risk of having longer and more severe depressive episodes, with a higher incidence of suicidality and poor responsiveness to treatment.

- Half of children with MDD meet criteria for at least one other psychiatric diagnoses. For example, the overall rate of comorbidity for anxiety and depressive disorders is 30% - 40%. Anxiety disorders tend to precede the onset of depressive disorders. For example, social phobia and being shy is often a forerunner of MDD, with an onset of 11.3 years. They are also at higher risk for suicidal ideation and behaviors. Disruptive Behavior Disorders are also often comorbid with adolescent MDD. Other comorbid disorders with adolescent MDD include PTSD, Eating Disorders, Substance Abuse Disorders, Learning Disabilities and chronic physical illnesses like irritable bowel syndrome. (Szigethy et al. 2007). There are multiple pathways to depressive disorders.
- An example of the comorbidity of substance abuse, depression and suicidal behavior was examined by Bagge and Sher, (2008). They noted that alcohol use can increase psychological distress, depressed mood due to neuropharmacological changes, alcoholic “myopia” which narrows alternative thinking and constricts cognitions, and results in interpersonal, academic and legal problems which are reasons adolescents attempt suicide. It has been estimated that 25% of youth who attempt suicide use alcohol or drugs at the time of the attempt. Subsequent substance abuse predicts reattempts.
- Epidemiological studies (Brown et al. 2007) have documented higher rates of internalizing disorders among Native Americans, Latino Americans, Asian Americans and African American adolescents compared to European American adolescents. Latino Americans reported the highest level of depressive symptoms of all ethnic groups. Symptom expression varies across ethnoracial groups. For example, the highest rate of somatic symptoms were reported by Latino and Asian American youth. (Anderson & Mayers, 201).
- The role of biological factors (5-HTT transporter gene) that has been linked to mood disorders, family processes, environmental/social risk factors and differential protective factors such as social support vary across diverse adolescent groups. See work by Caspi et al. (2003), Kaufman et al. (2004) and Kendler et al. (2005) for examples of the ways stressful life events and social supports impact on serotonin transporter system in predicting episodes of major depression.
- The role of acculturation, cultural identity as risk or protective factors varies across ethnic, gender and SES. There is a need to adjust therapeutic interventions with depressed youth based in ethnic/cultural needs. (Cardemil et al., 2010) (*Also see www.melissainstitute.org 13th annual conference on cultural sensitive interventions*).
- The gender ratio of diagnosable depression is roughly equal before puberty, but by early adolescence girls are two to three times more likely to be depressed than boys.
- One of the potential causal factors for this gender difference may be increased cognitive vulnerability among females (namely, the tendency to ruminate (brood about problems) and a negative inferential style (tend to choose more passive and less effective strategies for solving problems). Girls also possess a more negative orientation to problems relative to boys and a more negative view of self. They tend to focus on the fact that one is depressed,

one's symptoms of depression, and the causes, meaning and consequences of one's depressive symptoms. Stark et al. (2010) have developed a treatment for depressed girls.

- There are developmental changes in the expression of depression. Prepubertal children evidence more somatic complaints and psychomotor agitation, as well as comorbid separation anxiety and phobias. Adolescents evidence more anhedonia hopelessness, helplessness and hypersomnia.
- 30% of depressed adolescents will experience a relapse. Long-term follow up indicates that 50% of youth will have another depressive episode.
- Youth depression predicts low academic achievement and school failure, substance abuse and dependence, and later in life, unemployment and early parenthood. It is associated with psychiatric comorbidity and increased risk of attempted and completed suicide. Early-life depression also is associated with poorer long-term prognosis; depressed adolescents are less likely to earn college degrees, more likely to report lower incomes as adults, more likely to become unwed parents, and more likely to report experiencing stressful events in their lives (Fergusson & Woodward, 2002; Ritschel et al. 2011).
- Untreated, depressed adolescents are more likely to abuse substances, have difficulties establishing and maintaining close personal relationships, and underachieve in academic and occupational domains.

SOME FACTS ABOUT ADOLESCENT SUICIDE

(Research findings compiled from Berman et al., 2006; Brent et al., 2011; Goldston, 2003; Gutierrez & Osman, 2008; King, 1997; McIntosh, 2000; Miller, 2011; NIMH, 2008 and Noah et al. 2008). For a discussion of MYTHS CONCERNING SUICIDE see Joiner, 2010 and Miller, 2011.

- Adolescent suicide is a major health problem and accounts for at least 100,000 deaths in young people worldwide, according to the World Health Organization.
- Suicide is the third leading cause of death among 15 to 19 year olds in the U.S.. The typical youth who dies by suicide is an adolescent male using a firearm.
- On average, approximately five children and adolescents between ages 10 and 19 die by suicide every day in the U.S..
- Among young adults (15-24), there is one suicide for every 100 to 200 attempts. Nearly 20% of adolescents in middle school and high school report having seriously considered attempting suicide during the past year. Transient thoughts about suicide are quite common and even somewhat normative during adolescence.

- The Youth Risk Behavior Surveillance Survey (YRBS) found that nearly 15% of adolescents had made a specific plan to attempt suicide. 700,000 received medical attention for their attempts.
- Students who are most high risk for suicidal behaviors are youth who are at risk for dropping out of school or being expelled, youth in juvenile detention facilities, runaway and homeless youth, and youth placed in alternative schools or treatment centers.
- Boys who identify as being gay or bisexual are up to 7X more likely to attempt suicide than other boys in their high school.
- 10 % of adolescents, who attempt suicide, reattempt within 3 months, up to 20% reattempt within 1 year, and 20% to 50% reattempt within 2 to 3 years. Prior suicide attempts is one of the most important predictors of completed suicide, with a 30-fold increase risk for boys and a 3-fold increase for girls. With each repeated attempt, the risk of lethality increases as attempters use more severe methods.
- Around 80% of adolescent attempters and 60% of adolescent completers have a mood disorder.
- The presence of a co-morbid psychiatric disorder significantly increases the risk of suicide attempts, particularly conduct disorders and substance abuse. 90% of adolescents and 60% of preadolescents who complete suicide had a mental disorder. The most common mental disorder is mood disorders, then substance abuse and then disruptive behavior disorders. Other types of mental disorders include anxiety disorders, schizophrenia, borderline personality disorders, adjustment disorders and anorexia.
- The rate of suicide among adolescents has quadrupled since the 1950's. Brent et al. (2011) report that the adolescent suicide rate increased steadily from 1960 through 1990, and declined from 1995 through 2003. In 1993, the FDA issued their Black-box warning for anti-depressant that contributed to the decline in prescriptions and decline in adolescents diagnosed with depression. From 2004-2005, there was an increase in the rate of adolescent suicide.
- In the U.S., youth suicide is alarmingly high with a rate 3X the National Average. White youth have higher rates than African American youth, with Asian Pacific Islanders having the lowest rate. Hispanics have a relatively low suicide completion rate, but they are significantly more likely than either white or African American adolescents to report suicidal ideation. Suicide rates among Native American groups vary, but some groups have been found to be as high as 13 times the rate for all races. In recent decades, the suicide rate of African American adolescent males has risen substantially (increasing 200% from 1960 to 2000).
- Youth are at increased risk for suicide as they grow older, with adolescents (15-19) seven times more likely than youth between 10 and 14. Suicide does occur in children under the age of 10.

- In a typical high school class of 30 students, one student will seriously consider suicide, 2 or 3 (one boy and 2 girls) will attempt suicide, and one student will make an attempt sufficiently harmful to require medical attention.
- Surveys of youth in grades 9-12 indicate that:
 - a. 14.5% of U.S. students reported seriously considered suicide (18.7% of females and 10.3% of males).
 - b. 11% reported creating a suicide plan.
 - c. 7% reported trying to take their own life in the past 12 months. (9.2 % females and 4.6% males)
 - d. 2% reported making at least one attempt that resulted in an injury

Students placed in alternative high schools are 1.5 times more likely to report having seriously considered suicide or to have made a specific plan; twice as likely of having made an attempt and three times as likely to report having made a suicide attempt serious enough to require medical treatment.

- One half of those who are clinically depressed do not receive any treatment.
- Only 1 in 3 youth who attempt suicide receive help following the attempt. 45% of adolescents who attempt suicide do NOT attend one psychotherapy session after an emergency visit for their suicide attempt.
- Of those who do receive treatment, only about one-third of depressed youth who receive a combination of medication and CBT will have complete absence of depressive symptoms after 12 weeks of treatment.
- Many of those who do respond to treatment remain symptomatic. (Brent et al., 2011).
- The rate of symptom relief is much steeper in those who eventually remit. Suicide events tend to occur very early in treatment, with the average time to such an event being around 3 weeks. (Brent et al., 2011).
- Each suicide intimately affects at least 8 people.
- Recent years have witnessed major advances in the treatment of depressed and suicidal youth, including the use of Social Internet Media. However, it is critical to note that the Internet can also lead at-risk youth to material that increases their risk such as information regarding methods of suicide which can lead to increased lethality of attempts.
- Finally, it is important to keep in mind that suicidal adolescents have a particularly high risk for suicidal behavior during the period immediately following discharge from a psychiatric hospital.

ASSESSMENT STRATEGIES

The therapist needs to be familiar with warning signs, proximal and distal risk factors, as well as protective factors. The therapist needs to have knowledge of interview and psychological assessment tools and factors such as developmental issues that can exacerbate the patient's condition and that needs to be considered in the treatment formulation. The therapist needs to integrate this information into a Case Conceptualization Model that informs assessment and treatment decision-making and be able to document, document, and document the assessment findings.

YOUTH SUICIDAL RISK FACTORS

- Previous Attempts
- Depression and/or Substance Abuse
- Family history of mental disorders, Substance Abuse
- Stressful situation or loss
- Exposure to repetitive and excessive bullying that may be tied to sexual orientation, sexual identity and social rejection. Victim of cyber-bullying. The recent cases of youthful suicides attest to this risk factor (Cases of Phoebe Prince- - 14 years of age; Jaheen Herrera and Carl Joseph Walker-Hoover, both 11 years of age who committed suicide).
- Exposure to other teens who have died by suicide
- LGBT orientation
- History of physical and/or sexual abuse
- Poor communication with parents
- Incarceration
- Lack of access or unwillingness to seek treatment

YOUTH SUICIDAL WARNING SIGNS

- Depressed mood
- Substance abuse
- Frequent running away or incarcerations
- Family loss or instability, significant problems with parents
- Expressions of suicidal thoughts, or talk of death/afterlife
- Withdrawal from friends and family
- Difficulties in dealing with sexual orientation
- Anhedonia
- Unplanned pregnancy
- Impulsive, aggressive behavior, frequent expressions of rage
- Rumination- focus on the fact that one is depressed or one's symptoms of depression, and or the causes meanings and consequences of depressive symptoms. Repeated self-focused negative thinking (brooding).
- Sudden changes in behavior, friends or personality
- Changes in physical habits or appearance

- Non-suicidal self-injurious behavior (NSIB). Youth who cut themselves regularly have a significant risk of suicide.

STRONGEST PREDICTORS

- Previous suicide attempt
- Current talk of suicide/making a plan
- Strong wish to die/preoccupied with death (i.e. thoughts, music, reading)
- Depression (hopelessness, withdrawn)
- Substance use
- Recent attempt by friend or family member
- Suicidal plans/methods/access
- Making final arrangements

SUICIDE ASSESSMENT STRATEGIES: USEFUL MNEMONICS

(See Berman, 2010; Brent et al. 2011; Miller, 2011; Somers-Flanagan & Somers-Flanagan, 1995)

The American Association of Suicidality (AAS) have developed a useful mnemonic for remembering the warning signs of suicide.

IS PATH WARM?

- **I** Suicidal Ideation- threatened, communicated or otherwise hinted at such as by looking for ways to kill oneself
- **S** Substance Abuse - excessive or increased use of alcohol or drugs
- **P** Purposelessness - feelings of lacking in purpose, value or increased seeing no reason for living
- **A** Anxiety – increased anxiety, agitation or insomnia
- **T** Trapped – feeling like there is no alternative, no way out, other than suicide to escape intolerable feelings; need to terminate oneself to end feelings of shame or guilt
- **H** Hopelessness – feelings and/or thinking that nothing can or will ever change for the better
- **W** Withdrawal – increased isolation from family, friends, work or usual activities
- **A** Anger – feelings of rage, wish to seek revenge against alleged evil others, uncontrolled anger
- **R** Recklessness – acting with disregard for consequences, engaging in risky activities seemingly without thinking
- **M** Mood Changes – experiencing dramatic mood changes, cycling

ASSESSING PROXIMAL SUICIDAL RISK FACTORS (*Brent et al. 2011*)

AID ILL

A - Agitation – acute discomfort, arousal restlessness. Desire to escape this state

I – Intent – hopeless about the future and have suicidal ideation with a plan

D – Desperate – feel extremely sad to the point where it is painful and intolerable

I – Instability – due to mood liability, impulsive aggression, substance abuse

L – Loss of relationship or role

L – Lethal method – availability of gun or other lethal method

ASSESSING DISTAL RISK FACTORS (*Brent et al. 2011*)

SAD DADS

S – Suicide history – highest risk for reattempt within first 3 months after initial attempt, especially

if the intent has continued suicidal ideation and depression

A – Anhedonia – inability to experience or sustain positive feelings

D – Difficult course – failed response of treatment and becomes hopeless about the future and treatment

D – Difficult treatment history – history of nonadherence to treatment regimens

A – Abuse and trauma history and exposure to violence. Presently feels “trapped”

D – Disconnection – socially isolated and not involved with others. Feels marginalized.
Thwarted belongingness

S - Substance abuse

ASSESSING THE PLAN: SLAP

- Specificity: suicide plan details
- Lethality: how quickly could plan lead to death
- Availability: how quickly could patient implement the plan
- Proximity: how close are helping resources

MAP I3

- **M** – Motivation
- **A** – Access to Lethal Means
- **P** – Plan
- **I #1**- Intent
- **I #2** – Identifiable Victim (self or other, in case of homicidal threat)
- **I #3** – Inability to identify factors which might prevent them from following through

Assessment: SAD PERSONS

- Sex
- Age
- Depression
- Previous attempt
- Ethanol/substance abuse
- Rational thinking
- Social supports lacking
- Organized plan
- No spouse/unavailability of parent
- Sickness

Assessment: SAD PERSONS

- 3-4 = close follow up
- 5-6 = strong consideration of hospitalization
- 7-10 = hospitalization

D-HIPIS

1. DEPRESSION:
 - a. *How have you been feeling lately?*
2. HISTORY:
 - a. *Have things ever gotten so bad that you thought about killing yourself?*
(If no, document this, if yes follow below)
 - b. *Have you ever attempted suicide?*
3. IDEATION:
 - a. *Are you worried about killing yourself now?*
4. PLAN:
 - a. *Do you have a plan to harm yourself? When, where, how would they carry out their plan?*
 - b. *If they have a plan, do they have access to the firearms to carry it out? Are the means lethal?*

5. INTENT:
 - a. *How likely do you think it is that you will follow through on your plan? (Rate on scale from) 0 (no intent) to 10 (total intent)*
6. SELF-CONTROL:
 - a. *If you felt like harming yourself, what would you do to make sure you are safe? They should agree to contacting someone (parent or guardian or trusted adult) before acting.*

Note: Thoughts of death or wanting to “go to sleep” should be pursued, but are not specifically suicidal.

USE THE ART OF QUESTIONING

(Compiled from Brent et al., 2011; Jobes, 2006; Miller, 2011; Rudd, 2006; Shea, 2002).

Assessing Suicide Ideation and Behavior

Have you ever thought you would be better off dead?
Have you had thoughts of taking your own life?
Have you ever made a plan to commit suicide?
Have you ever had the intent to carry out your suicide urges/plans?
Have you ever attempted suicide?
If answer positive to any of these questions assess for specific details and examine the most serious episode.

Assess for the frequency and severity of suicidal ideation

For what proportion of the day do you find yourself having suicidal thoughts?
In a given hour, how much time are you thinking about suicide?
To what extent can you push away the suicide thoughts and think about something else?
On a scale of 1-10, if 1 is easy to push away, and 10 is completely preoccupied, where would you rate yourself?
To what extent do you feel you can resist suicidal urges (on a Scale of 1-10, where 1 is completely able to resist suicidal urges and 10 is not at all able to resist suicidal urges), would you rate yourself?

As a result of such probes, the therapist should be able to answer the following questions:

What method of suicide was contemplated and what was implemented?
How close did the patient come to completing suicide: For example:
 How many pills did you take?
 Did you put the razor blade to your wrist?
 Tell me what happened next?
How serious were the actions taken?
How serious were the patient’s intentions?

Did the patient tell anyone of the attempt?

Did the patient tell anyone beforehand?

Did the patient make the attempt in an isolated area or in a place where he or she was likely to be found?

Did the patient engage in preparatory steps (e.g., write a suicide note, say goodbye to significant others, give away prized possessions, take other steps?)

Was the patient's attempt well planned or an impulsive one?

How long did the patient think about this suicidal plan?

What other ways has the patient thought of killing oneself?

Did alcohol or drugs play a role in the attempt?

Were interpersonal factors a major role in the attempt?

Did a specific stressor or set of stressors prompt (trigger) the suicide attempt?

At the time of the attempt, how hopeless did the patient feel?

Why did the attempt fail? How was the patient found, and how did the patient finally get help?

How does the patient feel about the fact that the attempt was not completed?

What are some of your thoughts and feelings about the fact you are still alive?

Are you sorry your suicide attempt failed?

Can anyone be of help?

The clinician should assess for previous suicidal attempts.

What is the most serious past suicide attempt?

Does the patient view the current stressors and options in the same light as during the past attempts?

Are the current triggers and this patient's current emotional state similar to when the most

serious attempts have been made?

How many previous suicide attempts has the patient engaged in? Has the patient exhausted all hope?

Assess for Current Safety Plan

The clinician can ask:

What would you do later tonight or tomorrow if you begin to have suicidal thoughts again?

Right now, are you having any thoughts about wanting to kill yourself?

Do you still have the gun (pills) in the house?

Have you ever gotten the gun out with the intention of killing yourself?

In the past, what stopped you from pulling the trigger?

Assess for Protective Factors or "Buffers" to Suicide

The clinician can select from the following questions.

You have mentioned that your suicidal thoughts are pretty intense. What is keeping you from acting on these suicidal urges?

You have mentioned some reasons why you are thinking of attempting suicide. What are some reasons to keep on living? Is there any way we can make that stronger?

To what extent are you hopeful that treatment can help you? What would make you more/less hopeful?

To what extent do you regret having survived? To what degree do you regret having attempted?

Help me understand the reasons for hurting yourself or killing yourself?

What problem(s) are you trying to solve?

What would you tell a close friend who was in the same circumstances (situation)?

How else could you reasonably view your situation?

What steps can you take to begin to change your life, rather than kill yourself?

How might you make your life better in the future?

How can you reinvest in life?

What do you like best about yourself?

What happened recently that made you feel good?

The one thing that would help me no longer be suicidal would be _____ ?

Is suicide the best way for you to cope or change the situation?

Who are 3 people you will call if you are feeling like hurting yourself? (Get specific names and contact numbers). Which one would you be most comfortable in calling?

Promise me, that if you feel suicidal you will call _____ (not just leave a message) about how you are feeling before you try to hurt or kill yourself?

INTERVIEW QUESTIONS THAT CAN BE USED WITH DEPRESSED AND SUICIDAL CHILDREN

SAMPLE QUESTIONS FOR INTERVIEWING CHILDREN ABOUT SUICIDE IDEATION AND BEHAVIOR

(Source: Jacobsen et al., 1994. Interviewing prepubertal children about suicidal ideation and behavior. Journal of American Academy of Child and Adolescent Psychiatry, 33 (4), 439-451.)

Ascertaining the Presence of Previous or Current Suicidal Ideation or Behavior

1. *Did you ever feel so upset that you wished you were not alive or wanted to die?*
2. *Did you ever do something that you know was so dangerous that you could get hurt or killed?*
3. *Did you ever hurt yourself or try to hurt yourself?*
4. *Did you ever try to kill yourself?*
5. *Have you ever tried to make yourself dead?*

Assessment of Suicidal Intent

1. *Did you tell anyone that you wanted to die or were thinking about killing yourself?*
2. *Did you do anything to get ready to kill yourself?*
3. *Was anyone near you or with you when you tried to kill yourself?*
4. *Did you think that what you did would kill you?*
5. *After you tried to kill yourself did you still want to die or did you want to live?*

Interviewing Children Whose Grasp of the Concepts of Time, Causality, and Death May Not be Mature

1. *Do you think about killing yourself more than once or twice a day?*
2. *Have you tried to kill yourself since last summer/since school began?*
3. *What do you think would happen when you tried to ...jump out the window?*
4. *What would happen if you died, what would that be like?*

Assessing The Potential Impact of the Child's Current Emotional State Upon Recall of Suicidal Ideation or Behavior

1. *How do you remember feeling when you were thinking about or trying to kill yourself?*
2. *How is the way you feel then different from how you feel now?*

Determine Precipitating Factors and Risk Factors

1. *Have you ever thought about or tried to kill yourself before?*

2. *How have you been getting along with your family? With your friends?*
3. *Has anything happened recently which has been upsetting to you? To your family?*
4. *Have you had a problem with feeling sad? Have trouble sleeping? Not feeling hungry? Get angry easily? Feel tired a lot?*

Interview Parents about their child's suicidal Ideation and Behavior

1. *What exactly happened (step by step) on the day that your child spoke of wanting or tried to hurt him/herself?*
2. *How did you find out that your child was thinking about or trying to hurt him/herself?*
3. *What were you doing when your child was thinking about trying to hurt him/herself?*
4. *What happened after your child thought about, told you, or tried to hurt him/herself?*
5. *Is there anything else I should know that would help us better understand what led your child to the point of having suicidal thoughts and trying to hurt him/herself?*

The following ADOLESCENT ASSESSMENT PROTOCOL offered by the McArthur Foundation Screening Institute for Depression in Primary Care provides another screening tool.

Two Question Screen

During the past month, have you often been bothered by:

1. *Little interest in doing things?*
YES or NO
2. *Feeling down, depressed or hopeless?*
YES or NO

If patient responds "NO" to both, the screen is negative.

If patient responds "YES" to either question screen further.

Depressed Mood

How has your mood been lately?

Effects of Symptoms on Function

How are things at home/school/work?

How have (the symptoms-be specific) affected your home, school or work life?

Anhedonia (loss of interest)

What have you enjoyed doing lately?

Physical Symptoms

How have you been sleeping?

What about your appetite?

How is your energy?

Psychological Symptoms/Suicidal Ideation

How is your concentration?

Have you been feeling down on yourself?

Do you feel like life is not worth living?

Do you have any plans to hurt yourself?

How does the future look to you?

Have you thought about killing yourself?

Have you tried to deliberately hurt or kill yourself?

Joan Asarnow and her colleagues have assessed the risk of suicide, using two items from the commonly used Achenbach et al. measures: the Youth and Young Adult Self-Report Scales (YSR/YARS).

“I think about killing myself.”

“I deliberately try to hurt or kill myself.”

Youth are asked to answer these two items on a Scale ranging from 0 (not true) to 9 (very often or often true). These measures provide a brief screen for recent suicidal ideation and deliberate self-harm. (See http://www.sprc.org/featured_resources/bpr/ebpp-PDF/spec_emergency_rm.pdf)

This approach can be supplemented by direct behavioral assessment, using procedures such as the Imminent Danger Assessment developed by Rotheram-Borus and colleagues. This assessment strategy uses a series of probes to examine whether protective factors and adaptive coping can be mobilized in a brief evaluation/ crisis intervention session. (See http://www.sprc.org/featured_resources/ebpp_factsheets.asp#type)

The assessor tries to elicit 3 or more self-compliments.

- *What do you like best about yourself?*
- *What happened to you recently that made you feel good?*
- *What do you like better- your eyes or your hair?*

Try to elicit ≥ 3 positive comments regarding the youth from the parent/caregiver.
 Try to elicit ≥ 3 positive comments regarding the family from the suicidal youth.

Since many suicidal youth evidence other high risk behaviors such as substance abuse, the teenagers can be screened using the Radhert (1991) Problem-oriented Screening Instrument for Teenagers (POSIT) that attempts to identify “Red Flags”. Illustrative questions include:

Do you get into trouble because you use drugs or alcohol at school or work?

Do you ever feel you are addicted to alcohol or drugs?

Do you have a constant desire for alcohol or drugs?

Finally, suicidal individuals can be asked to **self-monitor** their moods and accompanying situations (triggers) and cognitions. For example, Rotheram et al. and Asarnow et al. ask youth to use a **Feeling Thermometer** that asks the patient to record the degree of comfort to distress from 0 to 10 and to note their reactions. Another valuable screening tool is the Columbia Suicide Screen (CSS) (Shaffer et al., 2004).

ASSESSMENT OF ONGOING SUICIDAL RISK-JOBES (2006) CAMS-COLLABORATIVE APPROACH

David Jobes (2006) has provided a practical and promising approach to the assessment of suicidal risk in his book Managing suicidal risk: A collaborative approach (New York: Guilford Press). Also see Jobes and Drozd (2004). This assessment approach is called **CAMS**, which stands for **Collaborative Assessment and Management of Suicidality**, and combines both quantitative and qualitative tracking measures and case resolution forms.

At the quantitative level, Jobes has the patient rate him/herself on six areas that include:

1. **Psychological pain and suffering** (anguish, misery)
2. **Stress** (feel pressured, overwhelmed)
3. **Agitation** (emotional urgency, feeling have to take action)
4. **Hopelessness** (expectation that things will not get better, no matter what you do)
5. **Self-hatred** (general feeling of disliking yourself)
6. **Overall risk of suicide**

These patient ratings are followed by the patient filling out a **Reasons for Wanting to Live and Reasons for Wanting to Die** forms and accompanying ratings. (Jobes provides a comprehensive rating system for the two Reasons Scales). There is also a set of Sentence Completion items that patients are asked to complete that are designed to capture the “nature of a patient’s suicidal mind”. Jobes has provided a comprehensive coding system for the clinician to code the patient’s responses, so this information can inform the treatment plan that the patient collaborates (“co-authors”) in establishing and implementing.

The Sentence Completion Items include:

- *“What I find most painful is...”*
- *“What I find most stressful is...”*
- *“I need to take action when...”*
- *“I am most hopeless about...”*
- *“What I hate most about myself is...”*
- *“The one thing that will help me no longer feel suicidal is...”*

The Collaborative Treatment Plan which is updated regularly covers the

- Problem Description
- Goals and Objectives and Evidence for Attainment of Specific Interventions (type and frequency)
- Estimated Number of Sessions

The Treatment Plan is designed to reduce Self-harm Potential and foster Outpatient Safety. A Crisis Response Plan is also formulated which emphasizes what a patient will do if he/she becomes acutely depressed, impulsive and suicidal. The patient is also asked:

“Were there any aspects of your treatment that were particularly helpful to you?”

“What have you learned from your clinical care that could help you if you became suicidal in the future?”

In the CAMS, there is also a **Checklist** for the clinician to fill out in order to assess the presence of **Suicidal Risk Factors** that include the presence of:

A Suicidal plan Preparation and rehearsal History of suicidality (Ideation, frequency, duration) Prior attempts (single, multiple) Current intent Impulsivity Presence of substance abuse Significant loss Interpersonal isolation Relationship problems Health problems Physical pain Legal problems Shame Mental status and DSM-IV-R multiaxial diagnosis.

Jobes also advocates that this Risk Assessment be accompanied by having patients fill out a symptom-based assessment tool such as the Brief Symptom Checklist SCL-90/Brief Symptom Inventory-BSI, the Behavioral Health Monitor- BHM and the Outcome-Questionnaire (OQ 45.2) that assesses symptom distress, subjective discomfort, interpersonal relationships and social functioning. (See Jobes, 2006, pp. 43-46). For example, the endorsement of the item on the OQ **“I have thoughts of sending my life”** can trigger the need for administering the CAMS. The CAMS is

administered using a side-by-side seating arrangement to reinforce the collaborative nature of the assessment process. This adjacent seating arrangement conveys to the suicidal patient that the clinician is trying to see the world through the patient's eyes.

Based on the documentation of these risk factors, the clinician is called upon to evaluate the patient's **Overall Suicide Risk Level**.

- **No Significant Risk**
- **Mild**
- **Moderate**
- **Severe**
- **Extreme**

The CAMS provides a practical, comprehensive and empirically-based way to collaboratively assess and manage suicidal risk and develop a suicide-specific treatment plan. A central message of the collaborative CAMS approach is”

“The answers to your struggle lie within you- together we will find those answers and we will work as treatment partners to figure out how to make your life viable and thereby find better alternatives to coping than suicide.”

“Let us see if together we can find viable alternatives to suicide to better deal with your pain and suffering” (Jobes, 2006, p. 41).

SELF-REPORT MEASURES

Brown (2002), Ghahramanlou-Holloway et al. (2008) and Range and Knott (1997) provide comprehensive reviews of suicide measures for adults. (Also see Goldston's review to be found on <http://www2.endingsuicide.com/TopicReq?id=1919>). A variety of measures have been employed including the Beck Scale for Suicide Ideation (SSI) and SSI-Worst, the Beck Depression Inventory-II (BDI-II), the Beck Hopelessness Scale (BHS), the Beck Anxiety Inventory (BAI), Suicide Probability Scale (SPS), Adult Suicide Questionnaire (ASIQ), Suicide Behavior Questionnaire (SBQ), Suicide Ideation Scale (SDS), Linehan Reasons for Living Scales (RFL-Adult and Adolescent Versions), and the MultiAttitude Suicidal Tendency Scale (MAST). For example, Bisconer and Gross (2007) found that in an inpatient setting the BDI-II was the best predictor of suicide, but **it also had considerable error**. These self-report scales need to be supplemented by other risk assessment tools (clinical interview, observational data, history of risk and protective factors and current ecological assessment procedures). The following list provides information on the self-report measures.

SELF-REPORT ASSESSMENT TOOLS

Suicide Intent Scale-SIS

(Reactions to suicide attempt-glad to be alive, ambivalent, wish they were dead predicts subsequent suicide attempts)

Lethality Scale

(Planfulness, efforts not to be rescued, seriousness of attempts)

Scale of Suicidal Ideation (SSI) and SSI-Worse (SSI-W)

Assesses suicide ideation, intent and plan (current) and at its most severe point in the patient's life. (Suicide ideation at its most severe point has been found to be a stronger predictor of suicidal risk than assessment of current ideation).

Hopelessness Scale

(Psychiatric patients who score 9 + are 11 times more likely to commit suicide than patients who score 8 or below). Hopelessness should be assessed over time. Stable levels of hopelessness, even in remitted depressed patients, are more predictive of future suicide attempts. The value of Hopelessness in predicting suicide attempts has been found to vary across ethnic and racial groups.

Depression Inventory- BDI-II, ≤ 20 (Mild) BDI ≥ 20 (Moderate-severe)

Also see Jobes (2000) **Collaborative Assessment and Management of Suicidality (CAMS)**

Assess for Possible Barriers (Scheduling conflicts, Health insurance, Child care, Transportation, Language and Cultural barriers, Compensation issues, Significant others interfere with treatment, Individual's "paralysis of will", Therapeutic-interfering behaviors)

Joiner (2005) in his book Why people die by suicide proposes that precursors of suicide include:

- a) An acquired capacity to enact lethal self-injury (e.g., engaging in high-risk behaviors);
- b) A sense that one has become ineffective and a burden to loved ones;
- c) A sense that one is not interpersonally connected with a relationship or group (sense of thwarted belongingness)

Joiner (2005, p. 227) assesses these attributes by asking such questions as:

a) Acquired Ability to Enact Lethal Self-injury

Thing that scare most people do not scare me.
I can tolerate a lot more pain than most people.
I avoid certain situations (e.g., certain sports) because of the possibility of injury
(Reverse scored)

b) Burdensomeness

The people I care about would be better off if I were gone.
I have failed the people in my life.

c) Belongingness

These days I am connected to other people.
These days I feel like an outsider in social situations (Reverse scored)
These days I often interact with people who care about me (Reverse scored)

As noted earlier, no one indicator is sufficient to predict suicide. Rather, the lesson to be remembered is that it is the combination of risk factors and the absence of protective factors improves the accuracy of suicidal risk assessment. For example, the combination of nonresponsiveness to treatment, treatment noncompliance, high scores on suicide ideation at worst period, and consistently elevated scores on Hopelessness Scale increases the level of suicide risk. (Ghahramanlou-Holloway et al. 2008).

Another factor to consider in the risk assessment is the presence of neurological involvement as in the case of Traumatic Brain Injuries and also in the changes in the adolescent's brain development, as the following summary highlights.

**DEVELOPMENTAL CONSIDERATIONS: CHANGES IN THE ADOLESCENT'S
 BRAIN DEVELOPMENT (TREATMENT IMPLICATIONS)**

“The teenage brain is a work in progress”
“Go to your room until your cerebral cortex matures”

A major concern of any assessment and treatment approach with adolescents is the need to tailor the interventions in a developmentally sensitive fashion, given the recent findings about neurological changes in the teenage years. A substantial amount of neural development occurs across the adolescent years, particularly in prefrontal cortex (PFC) regions of the brain responsible for higher-order processing. Portions of the PFC do not fully mature until the early 20's that are involved executive functioning, cognitive control, abstract thinking and the coordination of thoughts and behavior (Giedd, 2004; Rosso et al., 2004). Consider the following findings and the treatment implications.

Laurence Steinberg (2008, 2009 a,b) and Dahl and Spear (2004) have summarized the anatomical changes in the brain during adolescence.

1. There is a decrease in grey matter in prefrontal regions of the brain during adolescence, reflecting a synaptic pruning (namely, the process by which unused neuronal connections are eliminated), resulting in improved information processing and logical reasoning.
2. Changes in the dopaminergic activity involving a proliferation, reduction and redistribution of dopamine receptors in paralimbic or prefrontal cortical regions. Dopamine plays a critical role in the brain's reward system. This remoulding of dopaminergic activity can contribute to sensation seeking behaviors, given the youth's heightened salience to rewards.
3. Increase in white matter in prefrontal regions, reflective of myelination improving the efficiency of neural signalling. Whereas synaptic pruning occurs during early adolescence, the myelination process takes place toward the latter phases of adolescence and into early adulthood. This contributes to the development of executive functions, such as response inhibition, planning ahead, weighing risk and rewards and the consideration of multiple sources of information.
4. There is also an increase in brain connections among cortical areas and between cortical and subcortical regions. Such increased connectivity facilitates the development of emotional regulation and facilitates social information processing.

These structural changes and the accompanying changing patterns in brain activities contribute to the gradual development of self-management skills. As Steinberg concludes:

“Brain systems implicated in basic information processing reach adult levels of maturity by mid-adolescence. Whereas, those that are active in higher order executive functions, self-regulation and the coordination of affect and cognition do not mature until late adolescence or even early adulthood” (2009, p. 744).

Or described more poetically,

“The combination in middle adolescence of an early arousal reward system and a still immature self-regulatory system has been likened to ‘starting an engine without yet having a skilled driver.’”

From 14 to 16 (pre to mid-adolescence) impulse control, reward sensitivity, sensation seeking, risk taking, and reckless behaviors, and having an easily arousal reward system are all prevalent. From 16 to early adulthood, such behaviors as impulse control, anticipation of future consequences, strategic planning and resistance to peer influences increase.

Steinberg’s research demonstrates that the brains of teens lack the maturity to enable them to consistently control their impulses, resist peer pressure, fail to see future cause and effect consequences and appreciate the risks of their actions. They require “metacognitive prosthetic devices or tools” to develop self-regulatory and peer-resistant behaviors. Teens, especially in early adolescence, have reward-seeking arousal systems, but the ability to put the brakes on is still maturing.

Therapists need to adapt their interventions accordingly to meet these growing capacities. “Teenagers are less mature than we might have thought, especially, in the early stages of adolescence” (Steinberg, 2009).

TREATMENT IMPLICATIONS

1. There is a need to assess the cognitive capacity and meta-cognitive self-regulatory capacity of depressed and suicidal youth.
2. Need to provide the youth with “Meta-cognitive Prosthetic Devices” (MPDs), which may include Memory prompts, Advance organizers, Intermittent Summaries, Training in “Self-Talk” (“*What you tell your brain?*”), Problem-solving training and Ways to seek help.
3. Adolescents may respond and benefit more from behaviorally-oriented, concrete, direct-action oriented interventions such as Behavioral Activation and Activity Scheduling than to more cognitively demanding Cognitive Therapy procedures.
4. See Melissa Institute Website www.teachsafeschools.org for examples of how to build in MPD training, Miller at al. (2007) and Treatment Manuals by Joan Asarnow and her colleagues.

DOCUMENT THE RECORD

“If it was not recorded and documented, it is assumed it did not occur. Rather, think out loud for the record.”

Bongar and Stolberg (2009) propose that good record keeping is paramount and should include the following:

1. A systematic and thorough assessment of suicidal risk (present and past), and how this was determined by the therapist (Enumerate any measures that were used, the interview questions that were covered and the answers given).
2. Indicate the information that alerted the clinician to the suicidal risk.
3. List the risk and protective factors and actions taken (e.g., Include a copy of the Safety Plan, the Treatment plan and compliance data, for example with regard to psychotropic medication).
4. Document ongoing risk assessment and consultation efforts.

DOCUMENTATION

JOINT COMMISSION (JCAHO) ASSESSMENT

(<http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals>)

SUICIDAL DESIRE	CAPABILITY	INTENT	BUFFERS
	History of suicidal attempts		
Ideation	History of violence towards others	Expressed intent to die	Social supports
Hopelessness Helplessness Alone	Available means	Plan (method known)	Plans for future
Perceived Burden	Substance Abuse	Preparatory Behaviors	
	Mood Swings		Sense of purpose
	Increased anxiety		Religious beliefs
	Decreased sleep		Engagement with helpers

LEVEL OF SUICIDAL RISK

<u>Risk Level</u>	<u>Risk Factors</u>	<u>Protective Factors and Interventions</u>
Low Risk	No Current thoughts or risk factors present	Follow-up and monitor both symptom level and treatment progress
Moderate Risk	Current suicidal thoughts, but <u>no</u> specific plans Presence of multiple risk factors	Presence of protective factors like social supports; Patient engagement in treatment; Follow-up assess; Provide treatment for symptom relief Provide Coping Card Check treatment compliance
High Risk	Current thoughts Express strong Intent, has plans and has rehearsed Psychiatric diagnosis (comorbidity) with severe symptoms such as Substance Abuse Presence of acute precipitant events History of victimization Multiple Attempts	Admission to emergency treatment center; Develop crisis management plan; Ensure safety(*) (Provide details)

**(For example, indicate how the patient, family members and friends were educated about the signs of increased suicide risk, such as sleep disturbance, anxiety and agitation, suicidal expressions and behaviors. Provide them with emergency numbers and Website information www.StopASuicide.org, 1-800-273-TALK).*

ECOLOGICAL ASSESSMENT

I have been involved as a consultant in the assessment and treatment of both suicidal inpatient and outpatients. I have summarized the Lessons Learned in an article entitled “35 Years of working with suicidal patients: Lessons learned” which was published in the Canadian Psychologist, 2005, 46, 64-72). The Lessons Learned can be summarized in the form of nine questions that can be asked of the clinical staff. These include:

- i) What did they do to establish and maintain a therapeutic alliance with their suicidal patient?**
- ii) What specific assessment strategies and assessment measures (interviews, observational data, self-report measures, measures of current and past risk and protective indicators) did the health care staff employ on an ongoing basis to monitor the patient's suicide risk?**
- iii) How was this information conveyed to the suicidal patient (feedback) and to significant others in the patient's life (family members and to members of the treatment team)?**
- iv) What specific diagnoses (primary and comorbid) were formulated and how did this information impact the treatment plan?**
- v) What specific steps were taken to reduce the presence of risk factors (psychoeducation of patient and significant others, removal of risk factors, provision of aftercare interventions, provision of a specific safety plan and back-up supports)?**
- vi) What was done explicitly to address treatment adherence to psychotropic medications, address both barriers to treatment and antitherapeutic patient behaviors?**
- vii) What specific psychotherapeutic interventions were provided and evaluated for their efficacy?**
- viii) When the suicidal patient was an inpatient, what explicitly was done to ensure that the patient's safety (supervision, safety checks, maintain and communicate risk status to other treatment team members)?**
- ix) Where and when was all of these steps documented?**

When members of JACHO visit a psychiatric setting or when a patient suicide occurs, the staff should consider each of these nine questions, as well as the additional items I raised in my article in the Canadian Psychologist. The lesson to be learned is that suicide should not be viewed as a

result of the characteristics of a depressed patient, but as a byproduct of a complex transaction between an individual and significant others in his/her ecological and cultural niche.

For example, imagine that a recently discharged psychiatric patient commits suicide and you and the mental health workers are going to be sued for malpractice. In 25% of the cases of when a patient suicide has occurred, the family members sue the psychologist and his/her treatment center. If you were hauled into court because of a survivor's family lawsuit, do you believe that based on your progress notes you would be able to answer each of these nine questions? Where in your progress notes did you document on an ongoing basis the answers to each of these probes?

CLINICAL INTERVENTIONS

The treatment model that I have developed over the past 35 years of working with suicidal patients derives from a Constructive Narrative Perspective and incorporates a number of cognitive behavior therapy (CBT) procedures. There is an indebtedness to the work of Asarnow, Beck, Brent, T. Ellis, Joiner, Linehan, Rudd and their colleagues for their pioneering work in this area.

If suicidal patients have a specific manner in which they tell themselves, and others, “stories” that contribute to suicidal behaviors, then the question is how can psychotherapists help patients co-construct more adaptive stories and behaviors? I will consider below the Core Tasks of Psychotherapy and offer illustrations of possible intervention procedures. I will consider possible intervention procedures that are designed to not only alter the nature of the suicidal patient's narrative, but also nurture coping skills.

Consider the nature of the narrative of suicidal patients and the treatment implications.

IMPLICATIONS OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF SUICIDE

The following descriptions of the characteristic thinking patterns of clinically suicidal individuals highlight the cognitive vulnerability factors and sequelae of suicidal behaviors. Ellis and Rutherford (2008) have provided a similar account of the relationship between cognition and suicide. Consider what suicidal individuals have to tell themselves and others in order to convince themselves that self-annihilation should outweigh self-preservation. Below I will consider the assessment and treatment implications.

The nature of the “stories” that individuals who engage in other forms of suicide (e.g., “altruistic suicide”, suicide bombers, or end of life suicides) may be quite different and involve concepts of “perceived burdensomeness on others” and “self-sacrifice” for a higher good. (Joiner & Van Orden, 2008). Whatever the exact nature of such “story telling”, it is proposed that a CNP will help explain such suicidal behaviors.

CHARACTERISTIC THINKING PATTERNS OF SUICIDAL INDIVIDUALS: IMPLICATIONS

- a) dichotomous (black-white) thinking**
- b) cognitive rigidity and constriction**
- c) perfectionistic standards toward self and others with high levels of self-criticism**

- d) lack of specificity in autobiographical memory. Such overgeneral and vague autobiographical memory has been associated with depression, PTSD, and suicidal behavior. Ellis and Rutherford (2008) highlight that such overgeneral memories interfere with interpersonal problem-solving because past experiences cannot be used as references for effective coping strategies in the present.
- e) impaired problem-solving and poor problem-solving confidence
- f) “looming vulnerability” or the perceived experience of negative occurrences as rapidly escalating, mounting, quickly approaching adversities that generate distress (Riskind et al., 2000).
- g) such looming vulnerability can stoke hopelessness and helplessness with negative expectations about the future. (Anticipate few positive events or outcomes and accompanying vagueness in future thinking).
- h) ruminative process- - feeling “locked-in” to their current perceptions, unable to imagine alternatives, nor consider new courses of action.
- i) more present-oriented and view death in a more favorable light
- j) have difficulty generating Reasons for Living
- k) absence of protective factors such as attraction to life, repulsion by death, surviving and coping beliefs, sense of personal self-efficacy, moral and religious objections to suicide, fear of self-injury, and sense of responsibility to one's family

Examples of the Narratives of Suicidal Individuals

“I can't stand being so depressed anymore.” “I can stop this pain by killing myself.” “I am damaged goods.” (Schneidman, 2001 has characterized this intractable emotional pain as psychache)

“Suicide is the only choice I have.” (The word “only” is considered one of the most dangerous words in suicidology)

“My family would be better off without me.” “I was just a lifeless thing-breathing, but worthless. I knew everyone would be better off if I were dead. It would end my misery and relieve their burden.” “My death will be worth more than my life to my family”. (Joiner, 2005 and Joiner and Van Orden, 2008 have highlighted the perception of being a burden on others as related to suicidal tendencies).

“I am useless and unwanted.” (Joiner, 2005, highlights a sense of “thwarted belongingness”, as contributing to suicidal ideation and actions.) Perceive others as uncaring and unsupportive; feel socially disconnected and lack emotional intimacy.

“No one cares whether I live or die.” (Feel rejected, marginalized, worthless, unlovable, isolated, alone, and a failure)

“I am worthless and don't deserve to live.” (The presence of guilt, shame exacerbates suicidal ideation)

“I have an enemy within that I have to escape.” (Baumeister, 2004, has viewed suicide as a form of escape from self. It also reflects the “drama of the mind” that suicidal individuals are prone to engage in).

“I am in a tailspin, like a freight train or tsunami hit me. There is no hope. I can't get caught up. What is the point?” (Riskind et al. 2000 and Rector et al. 2008 have noted that anxious and suicidal individuals are prone to produce elaborate mental scenarios anticipating rapidly rising risk with multiply increasing threats. They tend to exaggerate the time course of perceived catastrophic outcomes and have an increased sense of urgency for escape and avoidance).

“I hate myself.” (Suicidal individuals have an over-generalized memory and tend to selectively recall negative events that contribute to invalidating themselves)

“I can't fix this problem and I should just die.” “Nobody can understand my intense feelings that I am experiencing.” (Tunnel vision, inflexibility in generating alternatives. Feel trapped and perceived inescapability)

“I would rather die than feel this way.” (Evidence poor distress tolerance)

“I have lost everything that is important to me.” “My future looks empty.” “Life is no longer worth living”. “Nothing will change.” “There is no hope for me.” (Ghahramanlou-Holloway et al., 2008, highlight the impact of such loss-related cognitions and the role of feelings of helplessness and hopelessness that exacerbate suicidal tendencies)

“I have screwed up, so I might as well screw up all the way.” (Perception that he or she does not deserve to live which contributes to suicidal ideation)

“Those who hurt me will be sorry.” (Perceived benefits of suicide, revenge).

“Suicide is a way of life for me and I can't stop it” (Kernberg, 2001)

IMPLICATIONS OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE (CNP) OF SUICIDE

- There is a need for the psychotherapist to become an “exquisite listener” of how suicidal patients tell their “story”, paying particular attention to the patients' thinking patterns and accompanying feelings and behaviors. There is a need to explicitly assess for suicidality and for the accompanying narrative.
- There is a need to determine the individual's capacity for self-injury and determine suicidal history, differentiating between single versus multiple attempters by conducting a detailed assessment.
- There is a need to be attuned to the presence of earlier victimization and the resultant

conclusions that patients draw about themselves, others, the world, and the future.

- There is a need to consider the role of developmental schemas, metaphors and images, mental and behavioral scripts and conditional assumptions (“If...then” rules) that predispose individuals towards suicidal behavior.
- There is value in specifically treating the cognitive vulnerabilities that predispose individuals to engage in suicidal behaviors. Recent studies that focused on reducing suicidal thinking (Berk et al., 2004; Brown et al., 2005) and on nurturing coping skills (Linehan et al., 2006) have reported a 50% reduction in suicidal behaviors. *(A description of such cognitive behavioral interventions is offered below.)*
- Interventions need to help suicidal patients transform hopelessness into hopefulness. Treatment needs to help suicidal individuals to develop healthy coping strategies, employ problem-solving skills to challenge and combat, what the English poet and critic A. Alvarez called **“The Savage God”**. As he described:

“Suicide is a closed world with its own irresistible logic...Once a man decides to take his own life he enters a shut off, impregnable, but wholly convincing world, where every detail fits and each incident reinforces his decision”.

Suicide may be seen as the only option, and even a “rational course of action”, as Aaron Beck (1976) observed some time ago.

While CBT is considered an effective intervention for a range of disorders (see Beck, 2005;Butler et al. 2006), debate continues about the mechanisms involved in instigating and maintaining such behavior change. In two Clinical Handbooks (Meichenbaum, 1994, 2002), I have offered an evidential model of change where patients collect data that is incompatible with their prior expectations and beliefs. Out of the strength of the therapeutic alliance, the therapist helps the patient accept such “data” as “evidence” to unfreeze the beliefs they hold about themselves, others, and the future. The psychotherapist also ensures that the patient has the courage and the intra- and interpersonal coping skills to undertake “personal experiments” that will yield disconfirming data. A variety of psychotherapeutic procedures including Socratic questioning, cognitive restructuring, problem-solving and coping skills training, and relapse prevention procedures may be used.

This evidential model of change is consistent with proposals offered by Brewin (2006), who noted that cognitive therapy does not directly modify negative information in memory, but rather influences the relative retrievability of different meanings of emotional content that is stored in memory. For example, some of the psychoeducational procedures described below (e.g., use of Clock metaphor, collaborative goal-setting and use of Time-lines that pull for the rest of the patient's story of strengths and signs of resilience), each illustrate ways to strengthen positive autobiographical representations. These interventions yield “data/evidence” that are in “retrievable competition” with the negative suicide-engendering representations and “stories”. These “mental heuristics” impact on the “internal debate” suicidal individuals engage in. When such changes come about, the psychotherapist needs to ensure that patients take personal credit and ownership for the alterations in ideation and behavior that they have brought about.

These various psychotherapeutic interventions are demonstrated in the recent APA film I made with a young lady, Missy, who attempted suicide seven times.

Before we consider specific interventions we need to first recognize the challenges of working with suicidal patients.

Meeting The Challenges of Working With Suicidal Patients

An important lesson to keep in mind is just how much energy and resources are required in conducting psychotherapy with suicidal patients. Suicidal patients have a high drop out rate from psychotherapy, they may be no-shows and often nonadherent to treatment plans, as well as evidence a number of antitherapeutic behaviors (being late, nonparticipation, denial, low distress tolerance and emotional explosiveness). As noted, only 20% to 40% of suicidal inpatients attend referred out-patient treatment services when they leave the hospital. The therapist has to be proactive in ensuring continuity of care, demonstrate flexible scheduling, use reminder phone calls, conduct phone sessions when needed, and engage a treatment team including the suicidal patient's family members (where indicated) in encouraging treatment compliance. The therapist needs to collaborate with the suicidal patient to anticipate and address potential individual, social and systemic barriers to treatment. A number of practical qualities of life issues (like housing, transportation, self-care) may also need to be addressed.

Such psychotherapeutic contact with suicidal patients should begin soon after a suicide attempt (within 72 hours), as suggested by Ghahramanlou-Holloway et al. (2008). Such early intervention with suicidal patients can even begin in emergency settings.

Critical Role of Early Interventions: Some Examples

The Challenge

- 50 % of adolescents who attempt suicide do not receive follow-up mental health treatment.
- Up to 77% of those who receive treatment either do not attend therapy appointments or fail to complete treatment.
- The dropout rate from therapy by diagnosed adolescents is 40%.
- There is a need for the development of early interventions that target commitment and engagement in treatment.
- These intervention procedures need to be culturally-sensitive.
- The earlier the intervention in the developmental course of suicidality, the greater the likelihood of treatment success.
- Four examples of Early Interventions come from Emergency Room , School and Clinical Settings and from an Integrative Ecological Approach, as described below.

EMERGENCY ROOM SETTINGS

Joan Asarnow and her colleagues (Asarnow et al. 2005; Baraff et al., 2001) have demonstrated that the Emergency Department is a site for intervening with youth to reduce suicide attempts. Suicidal youth tend to use more lethal methods with repeat attempts and most suicidal youth have substantial need for additional mental health services. 50% of suicidal youth are referred for follow-up care, but some 77% never attend such follow-up sessions and of those who do attend such sessions many fail to complete the full course of treatment. In order to address these clinical challenges, Asarnow and her colleagues have developed the **SAFETY Program—A Crisis Intervention Program for Adolescent Suicide Attempters (SAFETY= Safe Alternatives For Teens and Youth)**. The intervention program resulted in a 50% reduction in suicide attempts. A key feature of the **SAFETY Program** is family education.

The importance of parent education of suicidal youth is highlighted by the finding that 17% of parents either keep firearms that they own or purchased new firearms, even after their child's suicide attempts (Brent, 2000). Parents are 3 times more likely to take protective actions when parent education is provided.

One such program is the Family Focused Intervention for Suicide Prevention (**FISP**) which was listed in the Specialized ER intervention of suicidal adolescents, as developed by Rotheram-Borus et al. (2000). (www.sprc.org/featured_resources/ebpp/ebppfactsheets.asp#type). The **FISP** treatment components involve family education regarding the importance of follow-up treatment; the need for restrictions to lethal means; reframing the youth's suicide as a maladaptive coping/problem-solving strategy; developing a plan for coping with future crisis; ways to increase positive interactions and family support. Brent et al. (2011) and Brent and Poling (1998) also provide guidelines on how to engage parents as part of the treatment program for depressed and suicidal adolescents. For copies of Therapy Manuals for Adolescents and their Family Members visit the University of Pittsburgh Medical Center, Services for Teens at Risk (STAR) Center Publications.

www.starcenter.pitt.edu

Donaldson et al. (2010) and Miller et al. (2010) provide examples of various commitment intervention strategies that can be used with adolescents. (*See below for descriptions of these strategies*). Breland-Noble et al. (2006), Goldston et al. (2008), and Zayas and Pilot (2008) provide examples of how to tailor such interventions to African-American and Latino youth.

SUICIDE PREVENTION IN SCHOOLS

Miller (2011) and Miller et al. (2009) have provided a detailed enumeration of the goals, procedures and outcomes of suicide prevention efforts in the schools. Also see Goldston (2003). Gutierrez and Osman (2008) and Zenere and Lazarus (1997, 2009). The goals of these programs include:

- (1) increasing awareness about youth suicide
- (2) discussing and dispelling various myths and misinformation about suicide (See Miller,

2011, pp. 76-79 and Joiner, 2010).

- (3) increasing student recognition of risks and possible warning signs
- (4) changing attitudes about accessing help
- (5) providing information about resources in the school and community about how and where to get help
- (6) “Gatekeeper” training
- (7) teach students, health-enhancing behaviors like problem-solving, emotion-regulation and crisis management skills
- (8) nurture school connectedness by providing a positive school climate (e.g., implement and sustain a high ratio (4:1) of positive to negative statements directed toward students, incorporate “Spirit Days” throughout the school year, create a School Climate Committee, improve parent involvement in their child’s school activities, and the like
- (9) create a school environment that has a safe and orderly campus, caring and supportive school staff, high academic expectations, a challenging curriculum, parent involvement in their child’s school life and strong school-family relationships

Miller (2011) also discusses Suicide Screening Programs and Assessment Instruments and provides a caveat:

“There is currently no conclusive evidence that student screening programs for suicide are effective in actually reducing youth suicide or attempts” (p. 82).

Research indicates that discussing possible warning signs does not result in negative and unintended side-effects such as increasing negative behavior. Miller (2011) highlights that prevention programs should not include:

1. media depictions of suicidal behavior;
2. presentations of youth who have made previous suicide attempts;
3. outsourcing suicide prevention programs, rather than develop in-school expertise.

For a discussion of Student Case Law in Public Schools and whether school personnel can be held legally responsible for a student’s suicide, see Appendix A in Miller (2011).

CLINICALLY-BASED INTERVENTIONS

TREATMENT RESEARCH EFFECTS

(See reviews by Compton et al., 2006; Jacobs & Brewer, 2004; Kelly, 2010; McCarty & Weisz, 2007; Neil & Christenson, 2009; Weersing & Brent, 2006; Weisz, McCarty & Valeri, 2006. Also see www.melissainstitute.org review by Meichenbaum of these research findings).

OVERVIEW OF RESEARCH FINDINGS

There are more than 550 child and adolescent psychotherapies in use. Psychotherapy with youth has been found to be better than no treatment and youth psychotherapy appears somewhat less effective than adult psychotherapy.

Meta-analyses of evidence-based (EBT) psychotherapy with youth, compared to Treatments as Usual (TAU) yielded an Effect Size (ES=.34), and this ES decreased at a one year follow-up, indicating no lasting treatment effects. When EBT youth treatments were compared with bona-fide (stronger comparison groups), the ES decreased to .24 (Kelley et al., 2010).

A meta-analysis by Weisz et al. (2006) on the effects of psychotherapy for depression in youngsters revealed that treatment methods for depression are less effective than for other adolescent disorders.

In fact, the comparison literature with youth is quite “limited,” with only some 16 studies that meet randomized control standards.

Different youth psychotherapies have been found to be similarly effective.

Treatment dropout rates by youth from psychotherapy ranges from 28% to 85%. Youth engagement procedures such as the use of Motivational Interviewing is a critical component of treatment.

Research indicates that the quality of the therapeutic alliance is the most critical feature predicting treatment outcome with youth (Karver et al., 2005; Shirk & Karver, 2003; Spielman et al., 2007).

“The best overall risk management strategy remains a sensitive and caring therapeutic alliance within the context of the best possible clinical care” (Bongar & Stolberg, 2009, p. 10).

The efforts in developing a therapeutic alliance must be culturally sensitive and appropriate (See review by Anderson and Mays, 2010 on how race and ethnicity impact internalizing disorders in youth and Cardemil et al., 2010, on how depression prevention programs need to be culturally appropriate. You can also visit the Melissa Institute Website www.melissainstitute.org and download the papers to the 13th Annual Conference on cross-cultural interventions).

The therapeutic alliance with the parent is also critical in determining youth participation in treatment.

Such factors as the provision of a clear engaging treatment rationale, collaborative treatment planning, goal clarification with regard to outcome expectations, and a therapeutic “bonding” or support-building (perceived helpfulness, trust, and communication) and the development of hope were found to be predictive of treatment outcome.

Hope is a way of thinking about goals: a wish or desire for something accompanied by the expectation of obtaining it. Hope is the ability to produce pathways to attain goals (pathway thinking) and move on the path toward these goals (agency thinking). Hope and positive outcome expectations are interdependent processes (Snyder, 2005; Kelley et al. 2010).

Providing ongoing feedback such as parent ratings of the youth’s symptoms (Youth Outcome Questionnaire- YOQ Burlingam et al. 1996) and related feedback measures on a session-by-session basis has been found to enhance treatment outcomes (Kelley et al. 201), (See <http://www.talkingcure.com> of Scott Miller for examples of these measures and for examples of Bickman’s feedback measures see <http://peabodyvanderbilt.edu/ptpb>). Such data-based treatment decision-making enhances treatment outcomes.

In summary, the results of several studies (TADS, TORDIA and YPIC) are encouraging, especially if the quality of therapeutic alliance and treatment (session-by-session) feedback to both the patient and the therapist informs clinical decision-making. As Weisz et al. (2006) observe:

“For those who seek an alternative to antidepressants, psychotherapy offers a reasonable option, generating a small to medium Effect Size (ES =.34) that generalizes to comorbid anxiety symptoms and shows substantial holding power for some months after treatment ends.” (Weisz et al. 2006, p. 144).

The meta-analysis showed that treatments for youth depression have had beneficial, but modest effects on average. When steps were taken to better match the comparison of the designated treatment versus practising clinicians who provided treatment as usual (TAU) in clinical settings, the ES was reduced to .24. A number of evidence-based treatments failed to outperform usual care.

In two large multi-site randomly controlled studies, the combination of cognitive behavior therapy (CBT) and anti-depressant medication has been more beneficial than either treatment alone for adolescents with Major Depressive Disorder (MDD) (TADS,2007), and superior to medication alone for adolescents with treatment-resistant MDD (Brent et al. 2008).

These conclusions about the efficacy are consistent with CBT interventions with adults who evidence suicidal behaviors (Brown et al., 2005; Salkovskis et al. 1996; Wenzel et al. 2009) and consistent with the conclusions offered by Miller et al. (2007, p.33).

“The results of controlled studies as a whole indicate that outpatient

psychosocial treatments targeting suicidal behaviors directly, particularly CBT interventions, are effective in reducing the risk of future such behaviors in individuals identified as at high risk for them. In contrast, there is no data suggesting that inpatient treatments are effective at reducing suicidal behaviors.

These CBT approaches included self-monitoring of depressive symptoms, pleasant activity scheduling and behavioral activation, cognitive restructuring and social skills training. The social skills training component included ways to initiate a conversation, appropriate conversation topics, proper eye contact and facial expressions and assertiveness training. The training protocol also included family-based treatment modules. Youth and parents are taught about the connections between feelings, thoughts and behaviors and how this “negative” spiral can be interrupted in more adaptive ways. The psychoeducation should include a discussion about recurrence and risk factors, role of possible treatment barriers like stigma, warning signs, coping strategies, and benefits from treatment. Also, discuss adherence issues to medication and psychotherapy. Given the high reoccurrence of depressive episodes, especially when there has been evidence of internalizing problems before age 14, there is a need to educate about recognizing recurrence of depressive symptoms, so that treatment can be sought sooner than later.

A variety of psychotherapeutic engaging activities are used with youth. For example, Asarnow et al. (2005) use a “hot seat” game in which group members call out negative thoughts to the youth who is on the “hot seat” and who must immediately answer back with a more “positive” thought. Another group member serves as a “coach” for the youth in the “hot seat.” For younger children, CBT may include cartoon-like characters with thought bubbles above them where the child can write his or her thoughts. The therapist may use a Feelings Thermometer, a Feelings Watch, games, role play, and even have youth make a movie where they enact their learned coping skills. These movies are shown to their parents in a multi-family group, as a means to help their parents learn how to help their children use the coping techniques at home. (Asarnow, Scott & Mintz, 2002).

There is value in reviewing regularly with parents the work done with depressed youth, so they can facilitate these interventions at home.

There is a need particularly to build into CBT active experiential learning, particularly the hands-on activities. These activities may be play-based in which youth are taught ways to “run depressive thoughts off my land,” how to engage in a “good coach-bad coach,” ways to alter self-talk; and how to use a coping Fish Card Game, Coping Cat Workbook, and the like. In short, in order to foster full engagement of youthful clients, there is a need to include age-appropriate experiential, hands on activities. These CBT clinical interventions can be supplemented by school-based interventions. The following list of Websites provide examples of screening approaches, psycho-educational and experientially-oriented coping activities.

School-based Screening and Skills-oriented Training Programs

*theguide.fmhc.usf.edu/
elainet@u.washington.edu*

kalafat@rci.rutgers.edu
teenscreen@childpsych.columbia.edu
beth.mcnamara@comcast.net
highschool@mentalhealthscreening.org
school-basedmentalhealthtoolkit
lafrom@stanford.org
info@livingworks.net
Ask4help@yellowribbon.org

In addition, students can be encouraged to visit various Mental Health Websites for Adolescents (Review the websites before you recommend them).

www.CopeCareDeal.org
http://www.frozenflame.web.com/sparx.html
www.thelowdown.co.nz
http://au.reachout.com

Finally, there are increasing instances of where youth have died by suicide as a result of bullying or cyber bullying. Youth who are struggling with their sexual identity are particularly vulnerable to the pernicious effects of such bullying. See the following websites as ways schools can create a school-wide bully-proof environment.

www.teachsafeschools.org (Melissa Institute Website to combat bullying)
www.prevnet.ca

Wampold et al. (2002) conducted a meta-(re)analysis comparing Cognitive Therapy (CT) versus “bona fide” other therapies for depression and found that CT was not superior to other “bona fide” treatments for depression. Bona Fide treatments were those forms of psychotherapy intended to be therapeutic for depression. This meta-reanalysis highlights the incidence of non-specific factors such as the therapeutic relationship, belief in the treatment approach by the therapist, the role of a cogent treatment rationale in mediating patient improvement. The comparison between CT and “non-bona fide” treatments for depression yielded an effect Size of .49 which is the same as treatment versus placebo comparisons.

One of the factors that limits the effectiveness of treatment interventions with both depressed and suicidal adolescents and adults is the need to build into skills-based programs generalization guidelines. Psychotherapists should not merely “train and hope” for transfer (generalization and maintenance of the coping skills that are being taught). The following list (in the form of a Report Card) highlights the training technology that should be followed when conducting skills-based interventions.

ECOLOGICAL-BASED INTERVENTION

An integrative ecologically-based intervention called **CONNECT** was developed by Kristine Baber and her colleagues. The **CONNECT** program integrates various groups of peers, family, schools, clergy, gatekeepers in order to create a village approach (See below for a list of skills that can be included in such a model). For more information visit www.connectproject.org email: info@theconnectproject.org 1-800-242-6264.

COGNITIVE BEHAVIOR THERAPY WITH SUICIDAL PATIENTS

1. ESTABLISH AND MAINTAIN A THERAPEUTIC ALLIANCE WITH THE SUICIDAL PATIENT

(See Below for Specific Examples of “HOW TO” Implement these Core Psychotherapeutic Tasks)

“The importance of establishing a strong relationship with the suicidal patient cannot be overstated. Even the best therapeutic techniques are of little value when an adequate relationship has not been formed with the patient” (Rudd, 2006, P. 19).

“It is clear that the therapeutic relationship serves as the foundation for the entire treatment. We cannot underscore enough the importance of attending to the relationship between the therapist and teen” (Brent et al., 2011, p. 97).

The first and most critical task in working with suicidal patients is the ability to develop and maintain a good therapeutic alliance (*see below*) which can act as an excellent safe-guarding protective factor (see Messer & Wampold, 2002). Ghahramanlou-Holloway, Brown and Beck (2008, p. 162) offer sage advice on ways to establish a good working alliance with suicidal patients. They advise that the therapist should:

“Be attentive, remain calm and provide the patient with a private, non-threatening and supportive environment to discuss experienced difficulties. Do not express anger, exasperation, or hostile passivity. Be forthright and confident in manner and speech to provide the patient with a stable source of support at a time of crisis. Stress a team approach to the problem(s) presented; for instance, freely use the collaborative pronoun “we” when discussing suicidal behavior. Model hopefulness, but make sure to acknowledge the patient's distress and perspective on the problem. Do not avoid using the word “suicide” because this gives the impression that you stigmatize the concept. Most importantly, do not immediately suggest hospitalization. In our experience, patients are most agreeable if the therapist carefully explores various safety options, then plans for the most appropriate clinical response to an acute suicidal episode.”

Brent et al. (2011) highlight the need for the therapist to defer judgement, be flexible, collaborative throughout treatment, genuine, supportive, project self-confidence and appropriately use self while creating a safe, trusting, accepting therapeutic environment that is individually tailored to the needs of the suicidal client.

The following is a list of clinical activities that the therapist can include:

Have the patient tell his/her "story", at his/her own pace. Conduct a behavioral chain analysis of events of the proximal factors that triggered the suicide attempt. Involve significant others as a source of information concerning the suicide attempt. Ensure the patient's safety.

Help the patient define the suicidal crisis. Remember that the patient is communicating how badly he or she feels.

As noted, use "we" and convey a collaborative team approach in understanding the events (stressors) that triggered the thoughts of suicide. Use phrases such as "murdering yourself" or "self-annihilation" when referring to suicide.

Help the patient view suicide as an attempt to solve a problem (*see Section below for discussion of how to conduct problem-solving*). Convey that you do not want the patient to employ a "permanent solution to what might be a temporary problem". (Alter this message for patients with chronic medical conditions, such as Traumatic Brain Injuries or chronic illnesses).

Use Motivational Interviewing procedures. (See examples below for a discussion of ways to engage patients). Britton et al. (2011) and Zerler (2008) have discussed how to apply the principles of motivational interviewing of suicidal patients (EE, DD, RR and SS). The four principles of Expressing Empathy; Developing Discrepancy between the patient's present behaviors and values; Rolling with Resistance as the therapist strives to understand and respect both sides of the ambivalence from the patient's perspective. The therapist can empathize with the needs that give rise to suicidal ideation, without approving suicidal behaviors. Finally, the therapist can Support the patient's Self-efficacy by acting as a guide or consultant, suggesting possible ways to proceed. Convey to the adolescent that what you, the psychotherapist, are requesting of the youth to do may be "A lot to ask of you." "Solicit a commitment to delay killing oneself for an agreed upon period (four to six weeks) in order to permit the two of you to work together."

The therapist can empathize with the youth's wish to die and validate the youth's emotional pain, but not endorse suicidal behaviors.

The therapist can tap the suicidal patient's ambivalence about wanting to die and his/her desire to live with less pain. For example, Rudd (2006, p.10) suggests

"You've told me that you really don't want to die, but all of your behavior over the last few weeks suggest otherwise". (Therapist offers specific examples and solicits acknowledgment) "I need you to help me make some sense of this contradiction. It almost seems like your telling me one thing and doing another. Frankly, I am more

inclined to consider your behavior as more important, since I'm very concerned about your safety and well-being."

Use phrases such as "At the same time...", "On the one hand – but on the other hand..."

Address any barriers that may contribute to Therapy Interfering Behaviors.

Use collaborative agenda-setting and solicit the client's feedback about each aspect of therapy.

Brent et al. (2011) offer the following examples of how to collaboratively set an agenda:

"Is there anything on your mind you'd like to focus on today?"

"Do you have some ideas of what you would like to put on the agenda for our session today?"

"Did you have some experiences over the past week that you would like to discuss?"

Each session can include a summary and brief review of the last session so there is a continuity or flow to collaborative narrative of treatment, a solicitation of the patient's feedback on the last session, a review of "homework", a check-in regarding current mood, a suicidality check and a safety plan review.

Periodically summarize throughout the session and at the end of the session. As psychotherapy progresses, ask the patient to summarize what was covered in the session and what he/she plans to do between sessions and, most importantly, the reasons why he/she should conduct these activities ("homework" assignments). Build in reminders that the patient and significant others can take home.

Therapist should model hopefulness and "dogged determination" and convey a "team" approach. (I have often wondered why CBT is effective with depressed suicidal patients and one answer I have come to is that CBT helps to prevent depression in psychotherapists. The CBT therapist does not get depressed as he/she recognizes that the "story" that the depressed suicidal patient is telling is only "one story"--tuned into the depressogenic channel. It is the task for the CBT therapist to help the suicidal patient tell (and act upon) the "rest of the story" of strengths, resilience and survival instincts. (For an example, see my recent APA film with Missy who attempted suicide seven times).

Earn the patient's and his/her families' trust and confidence. They have to feel heard, respected, taken seriously, accepted and liked.

Discuss the issue of confidentiality and indicate what you, as a therapist cannot keep private. Share rationale for this needed procedure and solicit the patient's feedback. As Brent et al. (2011, p122) highlight:

"Without the teen's buy in, even the best treatment, provided by the best therapist, will not succeed".

Solicit feedback regularly from the patient and significant others. Ask:

“I want to check in with you about how you found our meeting today. Were there any things I said or did, or did not say or do, that you found particularly helpful? Or particularly unhelpful, or that bothered you? What can we do differently the next time we meet?”

The critical importance of a therapeutic alliance has been highlighted by Joiner (2005) and Joiner and Van Orden (2008). Under the heading of **Belongingness Therapy**, they describe the study by Motto and Bostrom (2001) who sent high-risk patients “caring letters” reflecting brief expressions of concern and reminders that the treatment agency was accessible when patients needed it. The “caring letter was personalized, signed by the person in charge of the person's care, and any note the patient sent in response to the previous letter was answered in the subsequent letter.

The “caring letter” that expressed caring and availability proved effective in reducing suicidality in patients who had refused further treatment after hospitalization. An example of the letter that was sent:

“Dear _____: It has been some time since you were here in the hospital, and we hope things are going well for you. If you wish to drop us a note we would be glad to hear from you”

Finally, there is value in conveying to the patient the need for open, direct communication and the critical importance of ongoing feedback. The following therapist message that was adapted from Miller et al. 2010 (p. 192) provides an example:

“I think I am a pretty good therapist, however, I’m not perfect. I make mistakes and I’ll probably do something over the course of our working together that will bother or upset you, maybe even piss you off and may cause you to consider dropping out of treatment. Now, let’s be clear. I expect you will also make mistakes. You may do things that upset me and piss me off. The point I am making here is that if you are going to get help we need to be sure that we keep the therapeutic relationship strong and working. This requires BOTH of us to be HONEST with each other if we feel there is a problem; if one of us upsets the other, even accidentally, we have to say to the other person, “Hey, when you said that, you upset me, you pissed me off.” We have to tell each other exactly what they did that was upsetting. Does this make sense and is it something we can agree on from the outset that we can work together as a team?”

2. PSYCHOEDUCATION

- Conduct assessment procedures. Provide feedback from the assessment and use the Case Conceptualization Model to help the patient and significant others better understand risk and protective factors.
- Use “stuckness” metaphor to convey that what the patient may have used once to survive and cope (e.g., dissociating, withdrawing, self-medicating using substances) may no longer be effective.

“When someone is exposed to extended bouts of stress, it can take a toll on the body and nervous system. As a result, they may stay on alert or sentry duty, even when there is no longer an immediate threat. Individuals can act out as if they are a faulty smoke detector”.

“Many things that you learned in the military served you well in your combat zones, but some of these same strategies may cause difficulties in your life now. Lets figure out what is working and what is not working.”

- Educate the patient and significant others about the disorders and the cognitive model of depression and suicide and the proposed treatment plan.
- Help the patient and significant others to appreciate the role of warning signs and the role of setting factors that may potentate suicide attempts (e.g., discontinuance of medication, sleep deprivation, substance abuse behaviors, manic episodes, disengagement and social withdrawal behaviors).
- Use self-monitoring, Clock metaphor, downward spiral explanation, ***as described below.***
- Negotiate a Safety Plan that prevents and manages risk factors that contribute to suicide risk and ways that the patient can obtain help, as described below. Determine the appropriate level of care and document this in terms of risk, protective factors and intervention steps.
- Provide bibliotherapy for both the patient and significant other. See Ellis and Newman (1996) (***Choosing to live: How to defeat suicide through cognitive therapy***)
- Use "urge" metaphor to describe suicidality.
- As part of the ongoing psychoeducation ensure that the patient
 - Has reminders of what went on during sessions and shares this with significant others
 - Has a self-help note-book that summarizes coping activities
 - Has a safety plan
 - Has crisis coping cards
 - Has an Anti-suicide Kit or Hope Chest with reminders of accomplishments and Reasons for Living (e.g. Scrapbook with pictures, mementos, Time Line 2 information, as described below)
 - Specific information about ways to contact health care providers

3. NURTURE HOPE

- Engage in collaborative goal-setting (Hope has been equated with goal-directed thinking). Focus on concrete attainable goals.

- Use a Scaling Procedure 0 to 10 of Hopefulness. Importance of Living Ruler (*see below*).
- Administer a Reason for Living Scale (Adolescent and Adult versions).
- Engage the patient in generating an Antisuicide HOPE KIT (*see below*).
- Introduce the patient to coping models.
- Involve significant others and adjunctive interventions.
- Assess and build on "strengths".
- Use Time Lines.--One can trace collaboratively with the suicidal patient and significant others *three Time Lines*. (See below for a detailed description of how to use these Time Lines as ways to nurture hope and begin the co-construction of a new narrative or "story".

Time Line 1- traces from birth to the present, the list of stressors and interventions

Time Line 2- traces evidence of individual, familial and cultural resilience and strengths

Time Line 3- engages the suicidal patient in collaborative goal-setting. This time line begins in the present and extends into the future

- Use Future Time Imaging Procedures (*see below*)
- Encourage the patient to reconnect with supportive and prosocial significant others and reengage in life tasks and undertake unfinished life projects.
- Convey that psychotherapy is concerned with "life-promotion" and not just suicide-prevention. It is designed to help patients develop a life worth living.
- Help the patient appreciate the progress that has been made.

4. TEACH COPING SKILLS

- Help the patient develop internal and external compensatory strategies.
- Address the patient's impulsiveness (*see below*) and nurture emotion-regulation and distress-tolerance skills.
- Build in Behavioral Activation and Activity Scheduling (*see below*).

- Engage in problem-solving and communication training with a focus on the problems that triggered the most recent suicidal attempt (*see below*).
- Conduct cognitive therapy of depression (*see below*).
- Increase the patient's adaptive use of social supports and develop ways to broaden social support network (*see below*).
- Use cognitive behavior skills training procedures (e.g., Self-instructional training, Stress inoculation training).
- Use mindfulness and acceptance treatment strategies, willingness to experience thoughts, feelings and situations fully, in a non-judgmental fashion. (See Hayes et al., 2004; Hofmann & Asmundson, 2008 and Ost, 2008).
- Use cognitive rehabilitation procedures (e.g., memory and attentional pictorial reminders and supports) in order to build in self-efficacy trials for suicidal patients with Traumatic Brain Injuries and other such patients (See Hogan, 1999, and Meichenbaum, 2002 as ways to apply CBT procedures with TBI patients).
- Help foster positive, supportive, "cognitive prosthetic" social environments.
- Increase the patient's use of and compliance with adjunctive services to be conducted in an integrated fashion (e.g., use of medication). Brent et al. 2008 recently demonstrated that depressed suicidal adolescents who do not have a clinical response to an initial trial of SSRI, (some 40%), benefit most from a switch to a combination of CBT plus another medication regimen, as compared to being switched to only another medication alone. There is a need to provide integrative treatments. When psychotropic medications are used it is helpful to discuss with the patient how the medication allowed the patient to behave differently (e.g., notice warning signs, seek help, play a different CD in his/her head). There is value in having the patient attribute improvement to what the medication has allowed him/her to achieve or do differently.
- Where indicated, treat PTSD symptoms (e.g., hypervigilance and hyperarousal symptoms, reexperiencing symptoms, restricted affect, detachment from others).
- Follow generalization guidelines such as using "homework" assignments, involving significant others, build in reminders, behavioral rehearsal, self-attribution or "taking credit" and relapse prevention procedures. Put the patient in a consultative role of showing, explaining and teaching. Use telephone consultation and home visits.

5. ADDRESS ISSUES OF COMORBID DISORDERS

Given the high incidence of suicidal behavior with such other disorders as Major Depressive

Disorders, PTSD, Psychotic Disorders, Eating Disorders, Substance Abuse, Personality Disorders and Medical Disorders, there is a need to provide integrative treatments. The psychotherapist has a choice to provide sequential, concurrent, or integrative treatments.

- Integrative treatments highlight for suicidal patients how their suicidal ideation and suicidal behavior developed (see the use of Time Lines below) and how such suicidal acts fit within a “vicious cycle” process and how they are interconnected with triggering events, emotional reactions, thinking processes, and behavioral acts and resultant consequences (*see the use of a Clock metaphor, discussed below*).
- Evidence-based interventions should be employed to address comorbid psychiatric disorders. For example, Prolonged Exposure procedures with PTSD patients, Cognitive and Interpersonal Therapies and Behavioral Activation Procedures for suicidal patients with comorbid Major Depressive Disorders, Relapse Prevention Interventions with Substance Abuse Disorder suicidal patients, Dialectical Behavior therapy Procedures with suicidal patients with Borderline Personality Disorder and Active After-Care Interventions.
- The challenge is how to maintain communication and a common message to the suicidal patient when there are multiple therapists. This is highlighted when psychotropic medications are combined with psychotherapy. Not only is there a need to provide adherence counselling to the suicidal patient across treatment agents, but there is also a need to provide a common psychoeducational model of suicidal ideation and behavior (See Meichenbaum, 2005).

6. RELAPSE PREVENTION PROCEDURES

- Need to equip the patient on how to deal with possible future adversities, lapses and reoccurrences, mood fluctuations and possible set-backs. (*"If I suffer a set-back, this does not mean that I am back to square one"*).
- Help the suicidal patient to decrease cognitive constriction and rigidity by learning how to engage in problem-solving in order to consider a wider range of possible options. Help the patient to chart a possible new course, accepting less-than-perfect solutions. (See Clum & Lerner, 1990; Salkovskis et al., 1990).
- Have the patient learn to use mindfulness acceptance skills as a means to reduce relapse (See work by Kabat-Zinn, Hayes and the book on Mindfulness-based cognitive therapy for depression as a form of relapse prevention training).
- Have the patient and significant others recognize how far he/she has come-- taking credit for improvement.
- Need to help the patient develop Reasons for Living and reclaim a life that is worth living.

- Have life-affirming experiences.
- Use relapse prevention tasks. Have patients visualize themselves in a future suicidal crisis. Use guided visual imagery of their employing their coping skills in dealing with the events leading up to suicidal crisis and ways to handle suicidal urges.
- Help the patient make good choices in response to “bad feelings”. Such imagery rehearsal procedures can be used as relapse prevention tasks involving past and potential stressful scenarios that might trigger suicidal ideation and suicidal behavior in a kind of stress inoculation fashion (see Meichenbaum, 2007). Successful accomplishment of such tasks can be used to determine whether gradual termination of treatment is required or whether further treatment is warranted. In this fashion, the length of the treatment is performance-based, rather than arbitrarily set ahead of time.
- Imagine possible obstacles and how these can be addressed.

" This time see if you can change the outcome. Can we go through this image again, but this time see if you can imagine coping with each problem as it arises? This time you are aiming for ending up with the best possible outcome. Imagine using the coping tools we have worked on "

- Raise such questions as:

Let's review our work together and the things we have figured out that tend to make you suicidal. What are you going to keep in mind at that time?

What kind of situations are triggers for you?

When you encounter W, you feel X, and you have the thought Y, and you do Z. (Use Clock metaphor of 12 o'clock being internal or external triggers; 3 o'clock being primary and secondary emotions; 6 o'clock being various cognitions; and 9 o'clock being specific behaviors and resultant consequences- - all of which contribute to a "vicious cycle").

You get a picture in your head of

Your brain tells you

You're telling yourself ...

Let's talk through the chain of events that led up to the suicidal attempt. Let's think of this as a video camera and in slow motion we can go over this and begin to change the sequence.

- Involve significant others like family members. The Family-based Cognitive-behavioral (FISP) interventions, as described by Asarnow, Huey, Rotheram-Borus, highlight the value of engaging parents to step-in and protect, while the suicidal youth develops coping skills. **FISP** works on enhancing family communication and problem-solving skills.
- Gradually taper treatment- once every two weeks, then once per month. Build in booster sessions every 3, 6, and 12 months.

7. COMBINATION TREATMENT OF PHARMACOTHERAPY AND CBT

- Antidepressant medication (SSRI) has demonstrated efficacy for youth. Need to use adequate dosage level. Monitor compliance. Continue medication for 6 to 9 months after recovery to ensure long-term success. About 40%-60% patients relapse after successful acute therapy. Many patients do not respond to initial treatment and require a treatment change at weeks 6 to 12.
- The combination of SSRI and CBT worked best in TADS study (Treatment Adolescent with Depression) JAMA, 2004,292, 807-820. Cognitive and Behavioral Practice, 2005, Vol. 12, No. 2. Brent et al. (2008). TORDIA study SSRI-resistant, JAMA, 299, 901-913. Weisz et al., Meta-analysis Psychological Bulletin, 2006, 132, 132-149.
- Assess symptomatology BDI <9 for 3 weeks as sign of improvement and functional roles and responsibilities.

CORE TASKS OF PSYCHOTHERAPY

These various clinical activities can be enumerated in the form of a set of core tasks of psychotherapy that cover the Introductory Phase, the Skills Training and Concurrent Interventions Phase and Follow-through Phase.

INTRODUCTORY PHASE

- **Establish and maintain a collaborative Therapeutic Alliance (TA). Monitor the TA throughout the course of psychotherapy.**
- **Be culturally, developmentally and gender-sensitive when conducting assessment and treatment.**
- **Use the “Art of Questioning”; Socratic discovery-oriented questioning that empowers the client. Do not be a “Surrogate Frontal Lobe” for clients. Use “How” and “What” questions.**
- **Solicit the client’s views about the nature of his/her presenting problems. Conduct a functional analysis; a behavior chain analysis of a specific distressing recent event; and a developmental life-span analysis using Time Lines.**
- **Ascertain the client’s views about what it would take to change (Tap Implicit Theories).**
- **Assess for the (1) history of victimization; (2) presence of both concurrent and sequential/longitudinal evidence of comorbid disorders like substance abuse; and (3) history of treatment interventions (timing, perceived efficacy, adherence and client satisfaction).**
- **Review with the client his/her “story” highlighting “the rest of the story”, namely “exceptions”, examples of coping and survival skills, strengths, signs of resilience, intra-and interpersonal resources. Ask “in spite of” questions followed by “How” and “What” questions.**
- **Use collaborative goal-setting and other procedures to nurture hopefulness. Use Motivational Interviewing procedures of Express Empathy (EE), Develop Discrepancy (DD), Avoid Argumentation (AA), Role with Resistance (RR) and Support Self-efficacy (SS).**
- **Assess for factors (potential barriers, roadblocks) that might interfere with the effectiveness of the intervention (e.g., developmental, peer-related, ecological and familial factors). Consider different class of client REASONS (Evidence-based; Self-consequential - - “If...then”; and Beliefs-based) that may undermine treatment adherence. Consider possible therapy Interfering Behaviors and collaboratively**

generate a “game plan” to anticipate and address these potential barriers. Consider how the psychotherapist may inadvertently contribute to treatment non-adherence.

- Formulate a Case Conceptualization Model of risk and protective factors and provide feedback to the client, significant others, and to indicated health care providers.
- Assess for risk factors toward self (suicidal potential) and toward others (potential aggressive/violent behaviors). Provide interventions to help de-escalate intense feelings and “high-risk” behaviors. Ensure client safety and collaboratively formulate a Safety Plan. Document, document, document Risk Evaluation and presence of Protective factors.
- Provide intermittent summaries throughout and solicit client feedback regularly. Engage client in formulating a Session Summary and develop “Action Plans” or “Homework Assignments”. Solicit client commitment statements and anticipate possible barriers and how these can be addressed should they arise.
- Solicit client’s feedback at each session using an “error-oriented” perspective. “What can be improved?”, “What can the therapist do better?”

SKILLS TRAINING PHASE

- Provide psycho-education in an engaging fashion. Use a variety of means to conduct ongoing education. For example, use the CLOCK metaphor.
 - 12 o’clock - - External/Internal Triggers;
 - 3 o’clock - - Primary/Secondary Emotions;
 - 6 o’clock - - Self-talk, images, thinking processes, beliefs/developmental schemas
 - 9 o’clock - - Behavior and reactions of others
- Help the client develop intrapersonal coping skills (e.g., emotional and behavioral self regulation, urge management, positive emotional development, psychological flexibility) and interpersonal coping skills (e.g., communication skills, social problem-solving; ways to nurture prosocial supports).
- Build in Generalization Guidelines. Do not merely “Train and Hope” for transfer. For example, nurture “expertise” which includes train to “mastery”, use deliberate goal-oriented practice; put client in a “consultative” role of teaching others, and enhance the ability to “mentalize” using meta-cognitive active transitive verbs (“notice, catch, interrupt, plan” and the like).
- Engage significant others to strengthen the generalization process.
- Ensure the client takes “credit” for behavioral changes. Engage in self-attribution procedures. Use the “Art of Questioning” of “What” and “How” questions, reinforce CHANGE TALK and the use of RE-VERBS.

- **Build in Relapse Prevention procedures.**

CONCURRENT INTERVENTIONS

- **Use evidence-based, best practices interventions.**
- **In an INTEGRATED manner address and treat the client for the presence of comorbid psychiatric disorders such as PTSD, Complex PTSD, Substance abuse, depression, suicidality and physical disorders such as Traumatic Brain Injuries, physical pain.**
- **Use target-specific interventions that are tailored to primary trauma-related problems and reactions (e.g., dissociation, anger problems, guilt, shame, complicated grief, moral injuries, substance abuse disorders and sleep disturbances).**
- **Help the victimized clients formulate a coherent “Healing Story” and develop meaning. Where indicated, incorporate spiritually-oriented interventions into the treatment process. Distinguish between positive and negative religiously-based coping strategies.**
- **Assess for the presence of Borderline Personality and Antisocial Personality features. Integrate skills-oriented treatment procedures and use a Constructive Narrative Therapy approach.**
- **Help the client avoid revictimization.**

FOLLOW-THROUGH PHASE

- **Use a Patient Checklist in order to consolidate learning and strengthen self-attributions for change.**
- **Build in follow-up and follow-through services. Thin out the treatment schedule, build in on-going telephone or e-mail consultations, booster sessions, involvement of significant others and other health care providers. Ensure Continuity of Care.**
- **If indicated, coordinate and collaborate with pharmacotherapy.**
- **Revisit Relapse Prevention Plans.**
- **Solicit Client Satisfaction evaluations, as well as that of Significant Others.**
- **Document treatment outcomes using both client and therapist evaluations.**
- **Care for the Helpers. Use Individual, Collegial and Organizational interventions to bolster Health Care Provider’s resilience. “Learn to leave it at the office”.**

DETAILED DESCRIPTIONS OF COGNITIVE BEHAVIORAL INTERVENTIONS

GUIDELINES FOR ESTABLISHING AND MAINTAINING A THERAPEUTIC ALLIANCE

1. Acknowledge and convey empathy for difficulties, challenges and hard times client has gone through.
2. Convey understanding difficulty talking about these issues and normalize hopelessness and suicidality.
3. Highlight that it takes personal courage to talk about, share, examine these issues.
4. Nurture a collaborative approach.
5. Provide an overview on advance organizer of the assessment and treatment process and solicit the client's permission to participate.
6. Convey availability and support and hopefulness and potential for recovery.

Consider the following examples offered by Rudd (2006) and Meichenbaum (2008).

“It sounds like you have had a very difficult time over the last few weeks. I certainly understand your being upset and angry.”

“I know it's difficult to talk about such personal issues, particularly with someone you've just met. It takes a lot of personal courage to do so.”

“Is there anything I can do to help you feel more comfortable and make it easier for you to talk? If you need to take a few minutes to catch your breath you can do that. Sometimes it's easier to talk after you've had a few minutes to relax.”

“Let me know if you wish to stop at any point and take a break.”

“Is it okay if I ask you some questions about X in order for us to make some treatment decisions together?”

“Given what you have been through it is not unusual for someone who is depressed, at times to feel hopeless and helpless, overwhelmed, and wish to escape and have thoughts about death or dying.”

“If it is okay with you, I would like to ask you some questions about X. These are questions I ask every patient I see, so I get a better understanding of what you are going through. If you feel uncomfortable at any time, please let me know. It is important that you feel comfortable to voice any concerns you may have.”

NURTURING A THERAPEUTIC ALLIANCE

QUESTIONS THAT ARE DESIGNED TO NURTURE A COLLABORATIVE THERAPEUTIC RELATIONSHIP WITH ADOLESCENTS

(See B. Bertolino, 2003, Change-oriented therapy with adolescents and young adults. New York: Norton; See D. Meichenbaum, 2004, Treating individuals with anger-central problems and aggressive behavior. Clearwater, FL.-dhmeich@aol.com)

The following set of questions are designed to help engage adolescents and their parents in therapy. As Bertolino (2003) has highlighted, small changes in the language and “story-telling” can open new possibilities for future change. The “art of questioning” is one of the most valuable tools clinicians can use.

1. Conduct a Situational Analysis
 - How often does the problem typically happen?
 - Where does it happen?
 - When does it usually occur and how long does it last?
 - When does it end?
 - Who is present?
 - How do they respond?
 - What have you tried to do to help address this problem?

Assume future solutions through future talk
 Use expression such as *yet* and *so far*
So far things have not gone right for you
 You haven't found a way to stay out of trouble yet

I would like to invite you to consider noticing any differences in the problems that brought you here and telling me about them when we meet again. For example,

Are there any changes when you get depressed?
How depressed do you become?
How long does the depression lasts?
What do you do with your depression?
Ask one question at a time.

2. Turn problem statements into goals and future actions
 - So you would like to see...
 - So one of the things we would focus on is to find a way to change...
 - So when you get the sense that..., what will be different for you?
 - So when you put the trouble behind you, I wonder (I'm curious) how will your life be different?
3. Translate the client's absolutistic statements that use “all”, “nothing” or that reflect “black-white” thinking into partial statements.

Much of the time...

In the last while...

Always?

Never?

Any exceptions?

4. Solicit feedback on sessions.

How was today's session?

What was helpful or unhelpful?

Did we talk about what you wanted to talk about?

Did we work on what you wanted to work on?

How was the pace of our session? Did we go too fast or too slow, or was the pace just about right?

Was there anything missing from our session that you would like to see us include in the next session?

Is there anything I should have asked that I did not ask?

Is the way we are proceeding to address your concerns fitting with the way you expect change to occur?

What ideas do you have about how I can help you with this?

I want to take the time to make sure I understand where you (or each person) are coming from. Is that okay with you?

I would like to hear your ideas about what you think should happen next in our sessions.

There are many possibilities. We could...or you could decide to...

What might make the next session a little better for you?

Are you okay with that?

I have to tell you that I am a bit confused about...

I'm still wondering if...

Correct me if I am wrong.

Are there any changes you would recommend for our future sessions?

Did you feel heard and understood?

Is there anything you would like me to do differently in future sessions?

How would you explain your experience in therapy today to others who might be curious?

What might make coming here again a little better for you?

I will be checking in with you regularly in order to find out what's been helpful to you, what's not helpful, what's working and what's not working. Is that okay with you? I want to find out what we have done together that has been of benefit to you. This way I will be able to learn from you if our working together has helped or if anything needs to change in terms of the service we provide or whether a referral to another service would be of more help.

5. Relapse Prevention Questions: Learning from setbacks (slips)

What signs were present that things were beginning to slip?

What have you learned from this setback?

What will you do differently in the future as a result of this knowledge/experience?

What can you do differently in the future if things begin to slip?
 Is there anything that might come up between now and next time we meet that might pose a threat (hurdle, barrier) to the changes you have made?
 Can you think of anything that might come up that would present a challenge (barrier) for you staying on track?

6. Taking Credit For Change

What have you noticed that has changed?
 What specifically seems to be getting better?
 Who first noticed that things had changed?
 When did you first notice that things had changed?
 What did you notice happening?
 What did you do that resulted in...?
 How did you get yourself to do that?
 How did you get that to happen?
 How was that different than before?
 How did that help you?
 Where did you get the idea to do it that way?
 What did you tell yourself?
 What do you think made the difference?
 If X were here, what would he/she say has contributed to the change you brought about?
 What does it say about you that you have been able to...?
 What kind of person are you that you have been able to ...?
 Where did this X (courage, will-power) come from?
 What kind of inner strengths do you draw on in such moments of difficulty/adversity?
 What kind of inner qualities do you possess that allow you to...?
 What would others say are qualities that you possess that help you when you need them?
 Consider how change comes about with your parents. How can we work together so these changes continue into the future?
 What have you already learned about how to make it through a day at school?
 How have you managed to go so many days in a row at school without having a X?
 How will you let people know when you become angry without hurting anyone else or yourself?
 Who will you want to be sure to talk to this week at school?
 Until we meet again next week, who can you depend upon (or call upon) when you begin to notice bad feelings (or trouble) coming on?

7. Fostering Generalization

Can you tell me a little about how things are since the last time we met?
 How can we use what we learned last week to help you deal with the problem you are having with...?
 Pretty tough situation. Is there anything you could do...?
 I am wondering if you could...
 What might happen if you...?

I am not certain you are ready for that yet.
 That sounds pretty hard. Maybe, we should think of something else to do...
 Why is it important to correctly guess what someone's intentions are or what they want?
 What, if anything, has been different since the last time we met?
 The last time we met, you mentioned that on a scale of one to ten, things were at a five.
 Where would you say things are today?
 Were you surprised by how you were able to...?
 What did you do differently?
 What did you do when you found out that...?
 Do you ever find yourself out there in your day to day experiences asking yourself the questions that we ask each other, here in our meetings?

USE MOTIVATIONAL INTERVIEWING PROCEDURES

A consideration of reasons that suicidal patients choose not to enter treatment and often drop out of psychotherapy highlights the need for the therapist to use a number of engagement and commitment strategies. Consider some of these reasons and the treatment implications.

Question the Need and Usefulness of Treatment

“I thought the problem was not serious enough to go for help.”
“I thought the problem would get better by itself.”
“I thought a family member or friend would help me.”
“I thought the therapy probably would not have done any good.”
“I would not have trusted the advice they would give me.”

Have Concerns About Consequences for Seeking Help and Consideration of Barriers

“I am concerned what others would think if I went to therapy.”
“I was afraid I would be hospitalized.”
“I did not know where to go for help.”
“I do not have transportation (insurance, child care, etc.) that would allow me to go for help.”

Belief-related Barriers

“I wanted to solve this problem myself.”
“Men don't appear weak.”
“I am beyond help.”
“We are all going to die anyway. What is the point?”
“I am ashamed to go for help.”

Keep in mind that individuals with the highest risk for suicidal behavior are frequently the least likely to seek help from others. A number of engagement and commitment strategies have been offered by Breland-Noble et al. (2006), Brent et al. (2011) Castro-Blonio & Karver (2010),

Donaldson et al. (2002) and Spirito et al. (2010). For example Miller et al. (2010) discuss how the following engagement and commitment strategies can be used with suicidal patients:

- 1) Use pros and cons analysis of participating in treatment
- 2) Play “Devil’s Advocate”
- 3) Use Foot-in-the-Door and Door-in-the-Face techniques
- 4) Connect present commitments to prior commitments
- 5) Highlight freedom of choice and absence of alternatives
- 6) Use principles of Shaping
- 7) Use “cheerleading” techniques

Consideration of the Pros and Cons Analysis to participate in Treatment. The therapist says:

“Let’s begin by thinking of some disadvantages of committing to treatment. These may include that treatment will take a huge effort, possibly too much effort to change some of your long-standing behavioral patterns. The time commitment necessary for group and individual sessions, as well as therapy homework assignments and phone consultations may be too much for you right now? However, by making a commitment to treatment, we will work together to help you achieve your goals of reducing your self-cutting, keeping you out of the hospital, and helping you stay in school so that you can graduate. So we should weigh out the pros and cons before you make a final decision” (Miller et al., 2010, p. 195).

Such discussions can be followed up with specific questions about possible barriers and how these can be anticipated and addressed.

“What do you think about going to therapy/counselling?”

“When you think about the problems you are experiencing, how many visits to a therapist or counsellor do you think it would take to get better?”

“We know that sometimes things come up that make it difficult for adolescents to go to therapy appointments. What are some things you can think of that might make it hard for teenagers to go to therapy/counselling? What might be a roadblock/obstacle in your situation?”

“We find that it takes time for therapy to help. Treatment usually doesn’t help anyone if they go only one or two times. It takes time for you and the therapist to get to know each other. Because of this, we recommend that people go to treatment at least six times to increase the chance that it will be helpful.” (Donaldson et al., 2010)

NEGOTIATE A SUICIDE SAFETY PLAN

Brent et al. (2011) provide a detailed discussion of how to negotiate a tailor-made Safety Plan in order to help suicidal teens “buy in”, so they can get through suicidal thoughts and urges without acting on them. They highlight the need to have the suicidal teens write out the steps of the Safety Plan as they create the Plan together with the therapist. The Safety Plan should include an assessment and elimination of any available lethal means in the patient’s environment, a list of key adult contact people who can be approached for help, trouble-shooting any roadblocks that might interfere with implementation, a set of Coping Cards that enumerate both internal (coping strategies) and external (help-seeking) strategies and ways to involve significant others like parents.

The suicidal patient's **Safety Plan** should include the contact information (telephone numbers) for

- 1) therapist or care worker
- 2) on-call therapist who can be reached after business hours
- 3) psychiatric emergency evaluation center
- 4) other local support services who handle emergency calls
- 5) significant others
- 6) also, record the reasons why it is important to make these contacts and seek assistance

Joan Asarnow and her colleagues (2007) have developed a **Safety Intervention Plan** for suicidal patients that highlights the need to create **SPATS**.

- S** a) **Safe Setting**--restrict access to dangerous and lethal methods. Increase time in safe settings.
- P** b) **People**--increase contact with safe people and improve interpersonal relationships
- A** c) **Activities**--increase safe activities, actions and behaviors
- T** d) **Thoughts**--increase hopeful problem-solving thoughts: decrease suicidal thoughts
- S** e) **Stress Reactions**--strengthen abilities to regulate emotions, tolerate distress, and improve coping skills

SAFETY PLAN
(From Brown et al. 2006)

When I notice the following signs:	Anxious, irritable, signs can't cope
That lead to:	Thoughts of suicide; withdrawal
I plan to do the following:	Try my breathing exercises; call my husband
When others notice the following signs:	Crying a lot; agitation
I would like them to:	Be understanding: be patient
I know that I am in serious trouble when I or others notice that:	I have impulsive thoughts; my outlook becomes gloomy
When I am in serious trouble I will	I will ask my mom to come by; I will go to the ER; I will call my therapist

CRISIS RESPONSE PLAN

“When I am acting on my suicidal thoughts by trying to find a gun (or another method to kill myself), I agree to take the following steps:

- Step 1: I will identify what’s upsetting me.**
Step 2: I will write out more reasonable responses to my suicidal plans
Step 3: I will remind myself of the Reasons To Live
Step 4: I will _____

These various steps can be tailored to the specific patient and include the location and phone number of Emergency Room services.

The Crisis Response Plan can also include various other Affective Coping and Distress Tolerance Coping Skills. (See Marshal Linehan’s Dialectical Behavior Therapy for examples of mnemonic-based emotion-regulation skills).

Physical self-soothing- relaxation methods

Cognitive self-soothing- distraction techniques (e.g., do enjoyable activity, recall positive memories, imagine a pleasant scene)

Acceptance- urges of self-harm often come in waves. Help the patient develop techniques to "ride out the wave of suicidality". Teach mindfulness skills.

Sensory self-soothing- use smell, sound, touch, warm baths, listen to music,

scented candles, massage

Following the negotiating of the **Safety Plan** and the **Crisis Response Plan**, the suicidal patient can be asked:

“On a scale of 1 (not at all likely) to 10 (very likely), how likely do you think you would be to follow your Safety Plan (Crisis Response Plan) during a time of crisis?”

CONDUCT A BEHAVIOR CHAIN ANALYSIS

“We believe that people do things for really good reasons. I am wondering if you and I could get curious together and try to figure out what those reasons may have been on the day you tried to kill yourself?”

Thus, begins Brent et al. (2011) suggested approach to invite the suicidal patient to become a co-detective in discerning the sequence of events that led to his/her suicidal behavior. A similar chain analysis can be conducted with the patient’s parents.

The therapist can use Socratic questions that focus on “**What**” and “**How**” questions such as:

“What was different that day?”

“What made it more likely that you would engage in suicidal behavior on that day, than the day before?”

“How did you come to the decision to try and kill yourself?” Walk me through the steps, if you can of what specifically happened that day and your thoughts and feelings.”

The therapist can use an imagery reconstruction procedure and what Wexler (1991) calls a Freeze Frame method in order to have the patient replay the sequence of events, in slow motion, (chain analysis) that contributed to the suicidal behavior. In this way, collaboratively the patient and therapist can begin to identify vulnerability factors, as well as the possible presence of predictive factors (associations, coping resources, religious beliefs, aspirations) that are also part of the chain. In this way, the therapist can begin to explore the ambivalence that suicidal patient’s experience. The therapist can also employ pictorial representative (empty chain link circles) that can be filled in by the patient.

USE TIME LINES

The psychotherapist can collaboratively generate **3 Time Lines** with the suicidal patient.

Time Line 1- traces from the time of birth to the present time, the variety of major stressors and when they occurred and the various treatment interventions (hospitalization, medication trials, psychotherapeutic efforts)

Time Line 1-

Birth (Note type of stressors and when) **Present**
 (Note year, types ,and duration of treatment) **Time**

Time Line 2- traces the signs of resilience and strengths that the suicidal patient, family and cultural group have evidenced. This Time Line 2 constitutes the “**rest of the story**” and “**in spite of**” events that were characterized in Box 6 in the Case Conceptualization Model. Note that Time Line 2 can also extend back in time prior to the suicidal patient's birth by referring to the signs of “cultural resilience” of the patient's forefathers and previous generations. “**How did they survive and cope? What are the lessons to be learned that have been passed down?**” Remember Brewin's (2006) proposal that psychotherapy helps patients retrieve, attend to and find meaning and hope in alternative “positive” memories. The use of Time Line 2 is a useful way to help suicidal patients co-construct a new, more hopeful story”.

Birth (Note Signs of Resilience) **Present**
 Strengths, Accomplishments, Coping Efforts **Time**

Survival Skills of Forefathers _____ *Birth* **Present Time**

Time Line 3- is designed to help the suicidal patient to establish future-oriented goals and to engage in a problem-solving set. The Time Line begins now and extends into the future. The use of these Time Lines helps the patient to accept the “good and the bad” in his/her history and provides an opportunity and context to become freer of old conflicts so that he/she can develop more adaptive ways of coping and begin to “restory” his/her life.

Present Time _____ Problem-Solving Steps **Future Time**

USE SCALING PROCEDURE AND IMPORTANCE OF LIVING RULER

Britton et al. (2011) discuss how to use Motivational Interviewing procedures with suicidal patients. They use a Scaling procedure of asking the suicidal patient. The therapist can ask the client to rate him/herself on a 0 to 10 scale for level of hopelessness at the end of the session and also ask how he/she would have rated oneself before the present session began. Hopelessness is a good predictor of suicidality. For example:

Therapist: I have a question for you. On a scale of 0 to 10, where 0 is not strong at all

*and 10 is extremely strong, how important is living to you right now.
(Use Importance of Living Ruler)*

Suicidal Patient: I do not know, I'd say a 5.

Therapist: What made you choose a 5 and not a zero?

Suicidal Patient: (Provides answer)

Therapist: It sounds like there are times when X occurs (solicit elaboration and acknowledgement) and at the same time you have thoughts about killing yourself, you also think about what life might be like if you could resolve some of your problems and reduce your emotional pain.

The following **IMPORTANCE of LIVING RULER** was offered by Britton et al. (2011, p. 22).

Step 1: Provide the client with the following instructions.

On a Scale of 0 to 10, where 0 is not important at all and 10 is extremely Important, how important is living to you right now?"

0	1	2	3	4	5	6	7	8	9	10
Not at all Extremely Important Important										

Step 2: After the client responds, ask the client:

What made you choose a (client's number) and not a zero?

Note: It is critical that the clinician ask the client why a higher number and not a lower number was chosen. When clients are asked to compare a higher number to a lower number, they begin to talk about reasons for living, which is the goal of this exercise. When clients are asked to compare a lower number to a higher number, they will talk about reasons for thinking about suicide, which would be counter to the goal of the exercise.

OPTIONAL

Step 3: If the client gives a zero ask:

What would have to change for you to choose a (higher number, i.e. 5)?

Note: Clients who give a zero have difficulty identifying reasons for living. When clients are asked what would have to change for the client to choose a higher number, they begin to talk about areas that they need to make changes in, which is consistent with the goals of motivational interviewing.

EMOTIONAL TOLERANCE, REGULATION and ACCEPTANCE

Teaching the suicidal patient the ability to tolerate, regulate and accept intense distressing emotions is a critical task of therapy. Strong emotions can interfere with the ability to think clearly and result in maladaptive high-risk choices.

Brent et al. (2011) and Miller et al. (2006) discuss a variety of skills training steps that include:

1. Educating the patient about emotions.
2. Teach the patient how to identify, label emotions (“If you can name emotions, you can tame the emotions”).
3. Teach the patient how to monitor his/her emotions using an Emotional Thermometer, including a “Boiling Point” of “no return”. Highlight warning signs- Also use the Clock Metaphor (*See below*).
4. Brent et al. (2011) use the metaphor of emotions are like a “Snowball rolling down a mountain” and that the patient needs to learn a variety of coping strategies.
5. Emotion regulation skills include the use of distraction procedures, self-soothing techniques, deep breathing and progressive muscle relaxation procedures, pleasant imagery, mindfulness skills, taking a time-out, communication and assertive skills training.
6. The inclusion of significant others such as parents in the training program.

BEHAVIORAL ACTIVATION AND ACTIVITY SCHEDULING

Behavior Activation (BA) involves encouraging the patient to engage in behavior that is reinforcing and enjoyable and that will entail the patient’s sense of mastery, accomplishment and self-esteem and to counteract avoidant behaviors including rumination. Brent et al. 2011; Dimidjian et al. 2008; Martell et al.2010; Ritschel et al. 2011; have discussed specific ways to conduct Behavioral Activation. The length of BA varies and may entail some 15 sessions over 12 weeks. The BA includes:

1. A functional analysis of the types of activities that the patient finds rewarding. Martell (2009) suggests that the therapist raise the following questions:

“What is your family like?”

“What kind of things have been fun for you in your life?”

“What is your life like when you are depressed?”

“Are there things that you are not doing now that you typically do when you are not depressed?”

“Are you taking steps to accomplish these things?”

When discussing these varied activities, carefully and sensitively determine if the patient freely chose these activities or whether they were imposed by others (e.g., parents pressuring adolescents to engage in certain activities).

2. Provide a Rationale for BA and how it relates to the patient’s personal treatment goals.
3. Help the patient to generate a List of Past Enjoyable Activities and help them to identify and choose tasks and activities that are likely to prove pleasant, reinforcing and can engender a sense of mastery and accomplishment.
4. Help the patient break tasks into smaller, manageable pieces.
5. Help the patient identify avoidant behavioral patterns and learn ways to “break free” from ruminative thinking.
6. Have the patient practice, mentally rehearse and role play ways they will implement behavioral activities. Discuss possible obstacles and roadblocks and how these can be anticipated and addressed.
7. Encourage the patient to engage in such activities even when he/she does not feel like it and at the onset of depressed moods learn how to use Opposite Actions. Derive benefits even when one does not feel like it.
8. Have the patient use a Daily Activity chart with the hours of the day, noting his/her activity scheduling. Use a gradual task approach and mood diaries and problem-solving worksheets.
9. Discuss with the patient how engaging in such activities impacts his/her mood, sense of mastery and accomplishment. “How enjoyable was this?” “To what extent did you feel a sense of accomplishment?”
10. Involve significant others such as parents in the discussion and implementation of the BA.
11. Use various Acronyms to provide reminders of when and how to implement BA activities. Three Acronyms that have been used are **ACTION**, **TRAP** and **TRAC**.

Martell (2009) and Ritschel et al. (2011) have used a Handout with an acronym **ACTION** to summarize the Behavioral Activation procedures.

Assess behavior. “What does this behavior do for you? Will you feel better or worse after you try this behavior? Are there other alternatives? Is the current behavior avoidant?”

Choose a behavior to try. List the specific actions you will take.

Try out this behavior that you have chosen. Take careful notes about how the behavior affected you.

Integrate the behavior into your regular routine. If this is a new behavior for you, how can you make it part of your daily life?

Observe the results of the behavior. Do you feel better or worse after you try this behavior? How does doing this activity affect your mood?

Never give up. Sometimes new behaviors take a little while to feel natural, and you may have to try again.

A second set of Acronyms used in Behavior Activation are **TRAP** and **TRAC**.

T Trigger or some event (Antecedent)
R Response or emotional reaction
AP - - avoidance behavior

T Trigger
R Response
AC - - alternative coping activity

These Acronym reminders help patients recognize and “break free” of avoidant patterns and empowers them to reengage.

ANTI-SUICIDE “HOPE KIT”

The HOPE KIT serves as a memory aid to be used at a time of crisis. It can be a Box in which the patient puts items that remind him/her of the Reasons to Live (e.g., pictures of loved ones, Bible verses, information gleaned from Timeline 2 of “in spite of” behaviors and survival skills).

USE FUTURE TIME-GUIDED IMAGING

Have the patient imagine a time in the future, noting the date, how old he/she will be and describe what is happening in his/her life. Where are they, what do they see around them, who are they with? Involve all senses. How do they feel about the image? Anything they can do to improve the image or anything that they would like to change? Discuss with the patient specific ways they can use their HOPE KIT and Guided Imagery technique to prevent a future suicidal crisis.

ADDRESS PATIENT’S IMPULSIVENESS

Some suicide acts are impulsive and interfere with effective problem-solving. There is a need to slow down impulsivity.

Teach the patient how to "procrastinate" suicide and how to "stretch out time".

Ride out suicidal urges. Use a riding the wave metaphor of emotions rising and then coming down. Help the patient recognize that suicidal urges are not constant and will pass with time.

Delay acting on impulse to self-harm using one's coping card so they learn how to ward off impulsive acts and maintain an emotional balance.

Compile and practice delaying strategies such as talking to someone, telephone therapist, engage in distracting tasks, sleeping, calling the suicide Talk line 1-800-273-8255 (TALK) or calling or visiting Emergency Center if needed.

Safeguarding one's environment so it is unfriendly to suicide. Collaboratively engage in safety planning. Involve significant others.

One way to help suicidal youth delay acting on their suicidal impulses is to use the quality of the relationship with the therapist as a means of delaying a suicidal response. Rotheram-Borus in the Imminent Risk Assessment asks the suicidal individuals to make a promise for "no suicidal behavior" for a specific period of time.

"Promise me that if you feel suicidal you will call _____ and/or call _____ (last) about your feelings before you try to hurt yourself."

Brent et al. (2011) offer the following example as a way to address the suicidal patient's impulsiveness.

"If we can work together for the next X weeks, I am going to ask you not to hurt yourself. If we are going to work together, I need a commitment from you today that you are going to give therapy a chance. I know what I am asking is not easy. Working together we can help you create a life that feels worth living."

"Getting help is not a sign of weakness, but rather a sign of strength and courage. A willingness to honestly think aloud about one's problem's."

"I want to empower (enable) you to become your own therapist, so you can handle whatever comes your way in life."

Rudd (2006) recommends the use of a time-limited Commitment To Treatment Statement (CTS) which is an agreement between the patient and clinician in which the patient agrees to make a commitment to the treatment process and to living. The CTS identifies the roles, obligations and expectations of both the clinician and the patient in treatment and the need to communicate openly and honestly about all aspects of treatment including suicide and ways to access identified emergency services during periods of crisis. (See Rudd 2006, p. 52 for example of CTS). For example:

Commitment To Treatment Statement

“I (patient’s name) agree to make a commitment to the treatment process. I understand that this means I have agreed to be actively involved in all aspects of treatment, including: (Clinician specifies the Treatment Steps).”

“I also agree to make a commitment to living. This agreement will apply for the next X months, at which time it will be reviewed and modified.”

Signed _____ Date _____
Witnessed _____

The Commitment To Treatment Statement is different from No-suicide Contracts that may give a false sense of security.

“The use of an oral or written “contract for safety” in the management of suicidality has been demonstrated to have serious limitations and to lack sufficient evidential basis for having a protective impact on acts of deliberate self-harm” (American Psychiatric Association, 2003, pp.5, 41-42).

“There is no empirical evidence supporting the effectiveness of no-harm contracts in preventing suicide.” (Rudd, 2006, pg.50)

PROBLEM-SOLVING SKILLS TRAINING

55% of adolescents report that they attempt suicide as a method to escape from what they perceive to be an unbearable situation. The therapist should help the suicidal patient reframe suicidal behavior as a failure in problem-solving. Donaldson et al. (2010, p.218-219) provide the following example of therapist statements that can be offered to suicidal patients.

“So, basically, you felt stuck and decided that the only way you could get out of this situation was to hurt yourself.”

“You couldn’t think of anything else to do that you thought would be helpful. So you thought you would solve the problem by escaping it or hurting yourself.”

“We can help you to learn how to get yourself ‘unstuck’ without having to hurt yourself.”

The therapist should help the patient and significant others to prioritize problems.

What is upsetting you the most?

If you could change one thing about your life, that is changeable, what would it be?

If we could wave a "magic wand," what changeable problem would be different?

What have you tried in the past to solve this problem?

*How did it work?
 What difficulties did you have in working on this problem?
 What do you think we could try differently now?
 How would we know if we were making progress?
 If you were changing, what would others notice?
 What difficulties might we anticipate that we can plan for?
 Why would working on this be important? What would change?
 Are you willing to work with me on addressing this problem?*

(In selecting a problem to work on , choose one that is potentially solvable and one that may have positive ripple effects)

Out of such social discourse, the suicidal patient can learn to:

1. Identify and list problems, discerning what are potentially changeable and unchangeable problems. Be very specific and concretely identify the problems.
2. Prioritize and specify problems worth working on and short-term, intermediate and long-term goals.
3. Explore the connections between perceived problems and suicidality.
4. Generate alternative plans and brainstorm all possible options and weigh the pros and cons of various solutions. (Use problem-solving sheets and Decisional Balance Sheets).
5. Decide on one solution and explore potential roadblocks. Break problem-solving into component parts and bolster self-confidence.
6. Implement and review consequences and evaluate progress.

The goal of this problem-solving activity is to increase the likelihood that the suicidal patient will take the “therapist's voice” with him/her. The psychotherapist can ask the suicidal patient:

“Do you ever find yourself, out there, in your day to day experience, asking yourself the questions that we ask each other right here?”

COGNITIVE RESTRUCTURING/COGNITIVE THERAPEUTIC PROCEDURES

- Use the "art of Socratic questioning" which focuses on the patient's thinking processes. Use imagery reconstruction of behavioral scenes or chain analyses. Trace external and internal triggers that led to mood elevations, increased hopelessness, breakdown of problem-solving, suicidal thoughts and behaviors. (**Downward spiral**)
- Help the patient identify, monitor and decrease suicidal ideation. Help him/her collect "automatic thoughts." Explore with the patient the “internal debate” of the suicidal mind

and the interpersonal aspects.

- Encourage, invite, entreat, persuade, convince and cajole the patient to consider alternatives to suicide. For example, the therapist could ask
“If you could solve some of your family problems, would you want to live?”
 - Help the patient reconceptualize "the cant's", "won'ts", the "absolutes" and the "negotiables", to widen fixed blinders, to think the "unthinkable" and to move beyond "only".
 - Learn how to challenge thoughts, instead of having an "emotional knee-jerk reaction" to situations.
- v. Help the patient label and rate emotions and identify "cognitive road blocks"
- Help the patient to monitor mood shifts and learn to ask oneself, *"What just went through my mind?"* Learn the link between feelings and "downer" thoughts and how to "jump start" adaptive thinking. Can collaboratively generate wallet size **coping cards**.
 - Help the patient learn how to note mood shifts and develop plans for coping with trigger situations. If ...then plans so the patient is not "blind sided" by feelings and events.
 - Educate about cognitive errors--all or none, black-white thinking, overgeneralization. Teach the concept of the "middle road".
 - Help the client move from "either-or" thinking to "both-and" thinking. For instance, the therapist can observe:

“I can see why you want both more independence and more respect, and at the same time, it is important to continue to have a close relationship with those you love in order to get support when you need it.”
 - Teach the patient how to question and challenge his/her thoughts and learn how to in still reasonable doubt. Thoughts don't always equal facts. Nurture the patient's sense of curiosity.
 - Help the patient learn how to use a Dysfunctional Thought Record and collect data. Identify triggers, core beliefs and forms of "emotional reasoning".
 - The therapist helps the patients examine their thinking patterns, their "If-then" assumptions, helpful and unhelpful automatic thoughts. Brent et al. (2011) use the metaphor of sleds going downhill who stay in the same pathway every time they go down the hill. *“Often, when individuals are depressed, their thinking patterns can get stuck in a pathway that maintains their depressed mood. They have to steer out of a pathway that is likely to lead to depression.” (p. 179).*

- Address issues of denial and avoidance as a form of coping technique. Use a "stuckness" metaphor. The patient is "stuck" using a coping technique that worked in the past, but is no longer adaptive in the present.

USE CLOCK METAPHOR

12 o'clock - external and internal triggers

3 o'clock - primary and secondary emotions

6 o'clock - automatic thoughts, thinking processes and core beliefs or schemas

9 o'clock - behaviors and resultant consequences

The therapist can use his/her hand to convey the **clock metaphor** by moving his/her hand slowly from 9 o'clock around to 6 o'clock. The therapist can say:

It sounds like this is just a vicious...(without completing the sentence), thus allowing the patient to interject- - "cycle or circle".

If you engage in such a "vicious cycle," then what is "the impact, the toll, the emotional price you and other's pay? Is that what you want to have happen?"

Moreover, what do you do with your emotions of X?(3 o'clock).

(The psychotherapist can treat the patient's emotions as a "commodity" to do something with. For example, does the patient "stuff" his/her emotions, explode, drink them away, etc?)

If the patient responds to the question, "What do you do with your emotions? with a reply of "I do not know", the psychotherapist can say, "I don't know either. How can we go about finding out?" In this way the psychotherapist is not, what I call a "Surrogate Frontal Lobe", doing the thinking for the patient, but rather a supportive "detective" and collaborative guide.

WAYS TO INCREASE SOCIAL SUPPORTS

Have the patient make a list of possible social supports. Brent et al. (2011, p. 204) provide a Social Circles Exercise that can be used to assess the patient's social support network. They also describe how to enhance the patient's interpersonal skills including training in direct

communication, active listening, assertiveness, ways to improve social success (grooming, hygiene, conversational skills and ways to maintain social supports).

Utilize family resources

Proactively develop healthy new social supports (e.g., join social club)

Teach the patient how to access and use social supports

Involve family members (significant others) in treatment with the patient's permission. For example, educate the patient's parents about the nature of depression and comorbid disorders and on ways they can provide support.

Help significant others understand that it is not dangerous to ask the patient how he/she is feeling.

Encourage the patient to let people know when he/she is suicidal.

Patients can be asked:

“Who are three people you will call if you are feeling like hurting yourself? Which adult or helper (counsellor, therapist) do you feel comfortable calling? What is their name and telephone number?”

- 1.
- 2.
- 3.

This activity is designed to challenge the patient's belief that “No one cares” and to ensure that the patient contacts “safe” supportive people (non-suicidal).

TREATMENT RESISTANT DEPRESSION

(Compiled from Asarnow, 2010 and Brent et al. 2011)

The Challenge

- 40% of depressed and suicidal adolescents will not respond either to CBT or to an SSRI antidepressant.
- The longer a depressive episode goes on, the harder it is to treat and the longer the period needed for recovery.
- By the end of treatment the depressed and suicidal patient is “often better, but not well” (Brent, 2011, p. 225).

- Only about one-third of depressed youth who receive a combination of medication and CBT will have complete absence of depressive symptoms after 12 weeks of treatment.
- Suicide events tend to occur very early in treatment, with an average time to another suicide attempt is around 3 weeks.

The Need For Consolidation and Maintenance Treatment

Brent et al. (2011) discuss the need for a subsequent 3 to 6 month consolidation phase that targets residual symptoms in an attempt to bring about full symptomatic remission. This is to be followed by a 6 to 12 months in order to maintain relapse prevention skills, given that depression is a recurrent disorder. Some chronically depressed patients may require more than 12 months of ongoing treatment to protect against recurrence.

Brent et al. (2011) discuss the following factors that may contribute to treatment-resistant depression. They include:

1. The **FIT** between the treatment choice and the diagnosis of the client. For example, patient's with bipolar disorder or psychotic depression may warrant different forms of treatment. Is the primary diagnosis correct?
2. The presence of **COMORBID DISORDERS** such as PTSD, substance abuse, ADHD, anxiety and physical medical disorders that warrant separate and additional interventions. Where possible, these interventions should be integrated, rather than parallel or sequential such as CBT and medication. See the TORDIA study for an example of such an integrated treatment approach with depressed adolescents.
3. The presence of severe **PSYCHOSOCIAL STRESSORS** that undermine and complicate treatment efficacy. For example, the ongoing presence of family psychopathology and family discord, victimization experiences, bullying, and the like.
4. An adequate **DOSE, LENGTH** and **ADHERENCE** to treatment. For example, in the instance of Cognitive behavior therapy (CBT) and Interpersonal Therapy (IPT), they warrant active engagement of at least 8 to 16 sessions. SSRI Treatment warrants at least 8-12 weeks of treatment of 20-40 mg of fluoxetine. Brent et al. (2011) highlight the need for therapists to obtain a detailed Time Line of the duration and dosage of each treatment to assess their effectiveness given the half-lives of antidepressants. *“Did treatment take?” “Was the patient adherent?” “What was the patient’s level of satisfaction with the treatments?” “Were there side-effects that mimic depressive symptoms and undermined compliance with the prescribed treatment regimen?”*
5. Were guidelines for generalization built into the treatment program so treatment was not a variation of “train and hope”, but rather that key elements such as treatment engagement, relapse prevention, putting the patient in a Consultative Mode (see Patient Checklist below) were built into the treatment regimen?

THERAPISTS AS SURVIVORS OF THEIR PATIENT'S SUICIDE

(See <http://myspace.iusb.edu/~jmcintos/basicinfo.htm>)

Consider the Challenge of Working With Suicidal Patients

- 1 in 4 clinical interns will have a patient who attempts suicide during their training and 1 in 9 will experience a completed patient's suicide.
- A practicing psychologist will average 5 suicidal patients per month.
- 25% of psychologists and 50% of psychiatrists will experience a patient's suicide.
- 1 in 6 psychiatric patients die by suicide while under active treatment.
- Approximately 50% of those who die by suicide in the U.S. will have seen a mental health provider at some time in their life.
- Work with suicidal patients is considered the most stressful of all clinical endeavours. One third of psychotherapists who experience a patient's suicide subsequently suffer from severe emotional distress. Several factors may contribute to such severe distress including failure to hospitalize the patient who has died; a treatment decision that the therapist may feel contributed to the suicide; negative reactions from the therapist's institution; and the fear of a lawsuit by the patient's relatives.
- 25% of family members of suicidal patient's take legal action against the mental health-treatment team.

WHAT TO DO IF YOU LOSE A PATIENT TO SUICIDE (Suggestions offered by Tom Ellis and American Association of Suicidality)

1. Procedural (Immediate)

- a. Notify supervisor**
- b. Notify director of services**
- c. Contact hospital/clinic attorney**
- d. Strongly consider connecting family**
- e. Consider attending funeral**

2. Emotional

- a. Attend to your own need to mourn**
- b. Seek support from your supervisor, colleagues, significant others**
- c. Use cognitive strategies to dispute dysfunctional self-statements and beliefs**
- d. Attend to your emotional needs**

3. Educational (later with supervisor or review group)

- a. Write a case summary, including course of treatment**

- b. Review case formulation identifying risk and protective factors**
- c. Review intervention strategies**
- d. See suicidology@USTO.APA.ORG for additional resource**

PATIENT CHECKLIST

As a result of participating in treatment, I have learned how to:

- _____ 1. Notice warning signs of when I am becoming depressed and experiencing suicidal thoughts and feelings.
- _____ 2. Be on the lookout for triggering events.
- _____ 3. Use my Clock Analysis of noting the (Internal/External) Triggers, (12 o'clock), the Primary and Secondary Emotions (3 o'clock), My Thinking Patterns and Automatic Thoughts (6 o'clock), and What I Do or my behaviors and how others respond (9 o'clock).
- _____ 4. Take action to break this “vicious cycle”.
- _____ 5. Monitor my moods and accompanying thoughts.
- _____ 6. Reduce risk factors and make sure where I spend time is “safe” and free from possible lethal items (firearms, drugs). Safeguard my environment so it is unfriendly to suicide.
- _____ 7. Ask for help from family members, friends, and my treatment team.
- _____ 8. Implement my safety plan.
- _____ 9. Use my Coping Cards as reminders to “jump start” my healthy thinking
- _____ 10. Procrastinate hurting myself and use my coping techniques.
- _____ 11. Challenge, test out and change my thoughts and thinking processes. Change my “internal debate”.
- _____ 12. Accept my thoughts and feelings and “ride out” the urge to hurt myself.
- _____ 13. Remind myself of the Reasons to Live. Visit my Hope Kit and add to it. Remind myself of my Time Line 2 evidence of my “strengths”, “signs of resilience” and “survivor skills”
- _____ 14. Use my problem-solving skills. View perceived threats, disappointments and provocations as “problems-to-be-solved”.
- _____ 15. Use my self-soothing techniques.
- _____ 16. Look for the “Middle Road” and use my “If...then” plans, and take off my “emotional blinders”.

- ___ 17. Develop a life worth living. Use my skills to escape, avoid isolation.
- ___ 18. Use my Future Imagery procedures.
- ___ 19. Take my medication as prescribed, and check with my doctor regularly.
- ___ 20. Cope with my lapses (relapses) and view them as “learning opportunities”.
 “Hot” cognitions are wake-up calls to use my coping skills and awaken my curiosity.
- ___ 21. Plan for future high-risk situations like anniversary effects, reoccurrences so I am not “blindsided”.
- ___ 22. Make a “gift” of what I learned and share it with others.
- ___ 23. Take pride in what I have been able to achieve.
- ___ 24. Recognize that I am on a journey, but not alone.
- ___ 25. These are some of the things I learned from my clinical care that I can use if I become suicidal in the future. In addition, I can also _____
- ___ 26. Other things I have learned as a result of therapy include: _____

I have found it useful to have the suicidal patient collaboratively fill out this **Patient Checklist** and give examples of each item they checked. It is critical to have the suicidal patients share this list of coping activities with significant others. It is important to have them “take ownership” by having the patients put into their own words why they are doing each task.

The major lesson I have learned in working with suicidal patients for 35 years is how much they have to teach me.

SUMMARY OF THERAPIST “TO DO” LIST WITH SUICIDAL PATIENTS

“Most suicides, although by no means all, can be prevented. The breach between what we know and do is lethal”.

Kay Redfield Jamison, Night Falls Fast. 1999, p. 25.

1. Establish, maintain and monitor the therapeutic alliance.
2. Use Motivational Interviewing Procedures.
3. Address any Therapy Interfering Behavior’s and possible individual, social and systemic barriers.
4. Conduct a thorough ongoing assessment of warning signs and risk factors, including the presence of comorbid disorders. Use the “art of questioning”, standardized Self-report measures and conduct an ecological assessment of degree of safety.
5. Assess for protective factors.
6. Formulate a Case Conceptualization Model and provide the patient and significant others with feedback.
7. Formulate a Level of Risk categorization.
8. Document, document, document.
9. Treat suicidality directly. Teach immediate coping and crisis intervention skills. Negotiate with the patient a Safety Plan and a Crisis Intervention Plan.
10. Build into any training program generalization guidelines. Do not “train and hope” for transfer. For example, teach ways to regulate emotions, increase distress tolerance, problem-solve, seek social supports. Provide ongoing telephone consultation. Implement treatment programs that are gender-sensitive, culturally-sensitive and developmentally-sensitive.
11. Conduct psychoeducation and nurture hope. (e.g., engage the patient in collaborative goal- setting, use Scaling procedures and Importance of Living Ruler, Reasons for Living Scales, Hopefulness Scales, Ask questions about “strengths” and survival skills, Generate a Hope Kit, Use Future Guided Imagery).
12. Solicit Commitment to Treatment Statement, as compared to No Harm Contracts which are contra-indicated.
13. Use Integrated Treatment procedures that address the presence and impact of comorbid disorders. Bolster resilience-engendering behaviors. Use Cognitive-behavior Therapy procedures that treat guilt, shame, anger, complicated grief, “moral injuries”.
14. Involve significant others (like family members) of suicidal patient in the intervention

program.

- 15. Conduct relapse prevention training.**
- 16. Know how to reintegrate a suicidal patient (student) back into setting (school).**
- 17. Ensure treatment adherence, especially to pharmacotherapy and to psychotherapeutic activities.**
- 18. Ensure continuity of care, follow-up and follow-through procedures.**
- 19. Conduct postvention procedures, where indicated.**
- 20. Provide ongoing supervision, consultation and support to health care providers who treat suicidal patients.**
- 21. Educate “gate keepers” on warning signs and risk factors and ways to intervene.**
- 22. Other “TO DO” tasks.**

AN INTEGRATIVE ECOLOGICAL APPROACH TO REDUCE SUICIDE: A SELF-ASSESSMENT TOOL KIT

Consider your level of “expertise” in regard to each Core Task. Next to each TASK that applies to your setting indicate E = Expert, BS = Budding Skill, and NA = Not Applicable.

SCHOOL SETTINGS

- _____ 1. Identify “high risk” students for developing depression and suicidal behaviors.
- _____ 2. Use Screening Self-Report Measures and other indicators.
- _____ 3. Have a referral system in place for identified students.
- _____ 4. Provide school-wide resilience-building activities.
- _____ 5. Provide evidence-based coping with depression course and build in generalization guidelines.
- _____ 6. Educate teachers and other “gate-keepers” about warning signs, referral procedures and myths concerning depression and suicide. Educate them about the adolescents’ “developing brain” and implications.
- _____ 7. Provide students with information about depression and suicide. Raise awareness and train them on how to be of assistance. (*For example, how to ask questions! “I am concerned about you. Are you thinking of hurting yourself? Are you thinking of suicide?”*)
- _____ 8. Incorporate discussion of suicide (facts, myths, Art of questioning, specific information about referral sources). Use role-playing and practice. Use class discussion, drama groups and demonstrations. Focus on Middle-School aged students (Grades 7 and 8).
- _____ 9. Have a drop-in center for students in need.
- _____ 10. Give out pens, have posters with Crisis Hotline numbers, Websites and Internet resources. Use bilingual posters and other information.
- _____ 11. Teach computer literacy skills and responsibility. Combat cyber-bullying and how to avoid Websites that encourage suicidal acts.
- _____ 12. Implement a bully-proof school-wide program, especially be sensitive to sexual orientation issues since gay, lesbian and transgender youth are most high-risk for victimization and suicide.
- _____ 13. Implement an explicit school-wide program to enhance school-connectedness.

- _____ 14. Identify, monitor, and when indicated, refer “high-risk” students to mental health agencies. For example, repeat suicides, students of parents who committed suicide, victimized students, (PTSD with comorbid problems), students who come from homes of marital conflict, homeless youth, runaways, students who are returning to school after a suicide attempt. Designate a staff member to identify and track such at-risk students and to co-ordinate secondary intervention programs and wrap-around services.
- _____ 15. Establish and maintain a good working relationship with local mental health center.
- _____ 16. Provide mental health services in school such as CBITS- - Cognitive behavior intervention training in schools.
- _____ 17. Include parents in any planned intervention programs. Have a Parent Night on “Meeting Student’s Mental Health Needs.” Indicate on School Website and Newsletter available services and how these can be accessed.
- _____ 18. When a student suicide occurs, be careful about possible contagion effects. Conduct a network analysis of the suicidal student and identify other potential “high-risk” students.
- _____ 19. Following a student or faculty suicide be cautious in how you conduct postventions. (Provide information and combat rumours; do not sensationalize the death; attribute suicide to the presence of a psychiatric disorder such as depression and not to cumulative stress that many students experience; consider how best to honor the suicidal individual). (*See FMHI Youth Suicide Prevention School-based guide*)
- _____ 20. Provide support to students and staff who were most impacted by the loss (See work on treatment of complicated grief reactions).
- _____ 21. Provide training and resources for staff on ways to address needs of depressed and suicidal students. Educate them about Social media Internet resources. Include a Professional Developmental Training on “Meeting the Mental Health Needs of Our Students.”
- _____ 22. Work with the media on how they should cover the story of a suicide in your school.
- _____ 23. Work with the School District to collect data on student mental health needs and collect and report data on the effectiveness of these interventions. School Superintendent should collect data on the degree of “Expertise” for each school. How many of Core Tasks are available in each school?
- _____ 24. What other Core Tasks should be added to this List for School Settings?
 a) _____
 b) _____

(Please e-mail suggestions to dhmeich@aol.com)

MEDICAL SETTINGS

- _____ 25. Train Primary Doctors and other gate-keepers on the warning signs, Screening Questions, assessment tools, Motivational Interviewing Questions for working with adolescents who are depressed and evidence suicidal potential. Include a discussion of epidemiological data, comorbid disorders, referral information, value of synergistic treatment approaches of psychotropic medication and psychotherapy, myths concerning suicide, the research on the adolescent's "developing brain" and the treatment implications.
- _____ 26. Provide detailed referral resources and ensure follow up and follow-through. (Most students in need never receive treatment and evidence non-adherence to medication).
- _____ 27. When prescribing antidepressant medication conduct adherence counselling procedures, involve parents, monitor side-effects and conduct follow-up assessments.
- _____ 28. In the Emergency Room, the medical team should conduct interventions with suicidal youth and their parents. Educate and engage parents in ways to implement a Safety Plan (remove guns, pills, monitor warning signs, use referral sources).
- _____ 29. When indicated, hospitalize suicidal youth and implement a collaborative treatment program. Ensure safety, while hospitalized and when discharged.
- _____ 30. Provide psychotherapeutic interventions, such as CBT, to depressed youth who have chronic physical illnesses.
- _____ 31. What other Core Tasks should be added to this list of Medical Settings?
- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

CLINICAL SETTINGS

- _____ 32. With referred youth use a multigating assessment approach and a Comprehensive Case Conceptualization Model with accompanying feedback procedures.
- _____ 33. Assess explicitly for suicidality and the presence of comorbid disorders.
- _____ 34. Use treatment engagement strategies and Motivational Interviewing procedures with both referred youth and their parents.
- _____ 35. Engage in Collaborative treatment goal-setting and monitor progress.

- _____ 36. Use evidence-based treatments (Individual, Group, Family, Home-based psychotherapeutic approaches).
- _____ 37. Build in session-by-session feedback from youth and parents for both the client and the therapist to inform treatment decision-making.
- _____ 38. Conduct treatment in a culturally and gender-sensitive fashion. Consider sexual orientation issues.
- _____ 39. Be sensitive to developmental issues such as changes to youth's "developing brain."
- _____ 40. Conduct adherence counselling, if medication is prescribed.
- _____ 41. Be sure to include parent education, participation, and where indicated, refer parents who are "in need."
- _____ 42. Connect back with the school and help with student transition, especially after a suicide attempt.
- _____ 43. How many of the following clinical skills do you feel "Expert" at implementing and for which do you want further skills training? (E = Expert, BS = Budding Skill)
- ___ 1. Develop, monitor, and repair "ruptures" in therapeutic alliance with youth and their parents.
 - ___ 2. Use treatment engagement strategies and motivational interviewing techniques.
 - ___ 3. Conduct suicide assessment, and where indicated, crisis management.
 - ___ 4. Assess for comorbid disorders. Conduct a developmental behavior chain analysis.
 - ___ 5. Assess for strengths and potential barriers.
 - ___ 6. Use a Case Conceptualization Model and provide feedback.
 - ___ 7. Use Time Lines and Collaborative Goal-setting as ways to nurture hope. Use a Hope Kit.
 - ___ 8. Use a Safety Plan, Informed Consent, (Do not use Behavioral Contracts to not harm oneself).
 - ___ 9. Assess for possible parent involvement in terms of psychoeducation, parent participation in treatment and family therapy.
 - ___ 10. Provide psychoeducation to youth and parents about the interconnections between feelings, thoughts and behaviors.
 - ___ 11. Use Pleasant Activity Scheduling and Behavioral Activation Procedures.
 - ___ 12. Teach skills in a gender, developmental and culturally-sensitive manner. Note the variety of skills to be addressed such as emotion-regulation, distress tolerance, problem-solving, social and communication skills, parent conflict resolution, and the like.
 - ___ 13. Build in Generalization Guidelines to increase the likelihood of transfer and maintenance of treatment efforts. Provide home-based interventions.
 - ___ 14. Conduct Cognitive Restructuring Procedures. Use of Coping Cards and

related procedures.

- ___ 15. Ensure training occurs in an experiential and engaging manner (e.g. “Hot Seat,” Metaphor, role-playing, movie-making, etc.).
- ___ 16. Treat the presence of comorbid disorders in an integrated fashion (e.g., PTSD, Substance Abuse, Anxiety Disorder, Conduct Disorder, Borderline Personality Disorder, Serious Mental Disorders like Bipolar and Schizophrenia).
- ___ 17. Conduct Relapse Prevention procedures.
- ___ 18. Provide ongoing telephone consultation and follow-through.
- ___ 19. Provide support and consultation to therapists who work with depressed and suicidal patients.
- ___ 20. Use Additional Resources
(See Websites and Reference Section for Treatment Manuals)

___ 44. What other Core Tasks should be added to this list of Clinical Settings?

- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

SPECIAL NEEDS SETTINGS

___ 45. Juvenile Justice Setting. Screen for depression, suicidality and comorbid disorders. Monitor carefully for safety and ongoing risk assessment. Refer for evidence-based Treatments.

___ 46. Overlooked Populations- Latino youth, homeless youth, run-away youth. Implement an active out-reach program. Use peer-based interventions.

___ 47. Native American Populations- - work with cultural groups and use cultural traditions and heritage. Use American Indian Life Skills Training Curriculum.

___ 48. What other Core Tasks should be added to this list of Special Needs Settings?

- a) _____
- b) _____

(Please e-mail suggestions to dhmeich@aol.com)

TREATMENT OF CHILDREN AND YOUTH WITH PTSD

ASSESSMENT PROCEDURES FOR CHILDREN WHO HAVE BEEN VICTIMIZED

Prior to interviewing the child about the trauma experience and history, the child should be put at ease. Explain why he/she is there; give a tour of the office; ask questions (age, about school, leisure time activity that they do; If I had three wishes ... ; I hope by coming here ... ; Tell me about what you think would be helpful for me to know about why your mom brought you here (or why you came).; When at times does X not bother you so much?)

Possible questions that can be asked of the child. The degree of directness in conducting interviews should be adjusted to the tolerance level and needs of the child (Nader, 1994). The interview can cover such areas as the:

1. **child's account of the traumatic event** (e.g., what happened, when, most frightening moments, immediate reactions, etc.) (It is helpful if the interviewer is well informed about the nature of the trauma. Assess for the child's possible distorted understanding of the event.)
2. **lingering effects on the child** (*see examples below*)
 - (i) Do you have any memories that come back to you about the event -- be specific -- that bother you? Do you sometimes feel as if this experience is about to happen again?
 - (ii) Do you have any trouble sleeping?
 - (iii) Do you have any bad dreams (nightmares)?
 - (iv) Have you experienced nightmares or flashbacks (pictures in your mind) in which you were reliving some terrible experience over and over again?
 - (v) Did you find that you often could not stop the memory of this event from popping into your mind, no matter how hard you tried to stop them?
 - (vi) Do you find yourself crying (sad)?
 - (vii) Did you become more jumpy, jittery, nervous or irritable since X occurred, as compared to before X occurred? Can you give me an example?
 - (viii) Even after this event was completely over, did you find yourself feeling much more weak and helpless than before?
 - (ix) Is it harder for you to enjoy yourself and play now than before this happened (or as compared to other kids)?
 - (x) Do you have trouble doing school work (studying), doing chores around the house, playing, watching television, working at your job?
 - (xi) Have you become less interested in seeing friends and doing things?
3. When does X not bother you as much? **prior (or concurrent) exposure to other stressors** (*See Masten et al., 1993, Lifetime Events Questionnaire; See Rudolph & Hammen, 1999, Child Episodic Life Stress Interview*)

- i) Have you ever been hurt by anyone? ... touched in a way you didn't like? ... treated in a way you didn't like?
- ii) Have you ever seen something that really scared you?
- iii) Have you ever had a very bad experience?
- iv) Have you ever had nightmares?
- v) Has anything happened in the past year that has upset you (or your child as administered to parent), or caused you (your child) trouble?

Possible Questions

(From Deblinger & Hope, 1996; Faller, 1990; Meichenbaum 1995; Pynoos & Eth, 1986)

Why did your mom bring you here today?

What do you understand about why you are here today?

Did your mom tell you anything about why you were coming here?

Ask questions that put the child at ease (factual questions about school, hobbies, pets, television programs, etc.)

One of the things I do is talk to kids about things that get them upset or that makes them feel worried. Can you think of anything that has made you feel upset?

(Introduce topic of person who was involved in abuse situation.)

Has anyone ever done anything that makes you upset or worried?

What does X do that makes you upset?

Is there anything that X does that you don't like?

Tell me more about that?

What happened next? *(Help the child share feelings and develop vocabulary for emotions.)*

Can also use **Lifebook** (*includes answering sentence completion - See Examples of Child Diary, below*). Also, include mementos, snapshots, drawings, collage, story writing, letter writing and play for assessment purposes. Gil (1998) suggests **observing children's play activities** as a means of assessment. The therapist should note:

1. toys selected and the sequence of selection
2. themes in play and possible re-enactments (repetitive actions) and use of protective arts and powers
3. relationship between play and the child's situation
4. solicit accompanying stories
5. interaction with the therapist (or other children) during play

4. assess child's social supports

- i. When you need help, who helps you the most?
- ii. If you were absent from school, who besides your friends would notice you were absent and would miss you?
- iii. When was the last time you went to church and who took you? (*Particularly relevant for African-American males.*)

Also, can have child draw a **Genogram** for both in the home and outside of the home- Note, past (developmental) and current **attachment figures**.

See references below by Cohen et al. (2006), Deblinger & Heflin (1998), Jaycox (2003) and Smith et al. (2010).

Anderson, E.R. et al. (2011). A creative approach to teaching anxiety management skills in children. The Behavior Therapist, *34*, 3-7.

Garber, J. & Weersing, V. (2010). Comorbidity of anxiety and depression in youth: Implications for treatment and prevention. Clinical Psychology: Science and Practice, *17*, 293-306.

Liddle, H.A. (2010). Treating adolescent substance abuse using multidimensional family therapy. In J.R. Weisz & A.E. Kazdin (Eds.). Evidence-based psychotherapies for children and adolescents. (pp. 416-432). New York: Guilford Press.

Waldron, H.B. & Brody, J.L. (2010). Functional family therapy for adolescent substance use disorders. In J.R. Weisz & A.E. Kazdin (Eds.). Evidence-based psychotherapies for children and adolescents. (pp. 401-415). New York: Guilford Press.

ADVERSE CHILDHOOD EXPERIENCES (ACE QUESTIONS AND RESPONSE CATEGORIES)

Edwards, V. J., Anda, R. F., Dube, S. R., Dong, M., Chapman, D. P., & Felitti, V. J. (2005). The wide-ranging health outcomes of adverse childhood experiences. In K. A. Kendall-Tackett and S. M. Giacomoni (Eds.), *Child victimization*. Kingston, NJ: Civic Research Institute.

ACE Category	Question(s)	Response Options	Criterion for Category
Physical Abuse: Did a parent or other adult in the household;	Push, grab, shove or slap you? Hit you so hard that you had marks or were injured?	Never, once or twice, sometimes, often, very often.	Often and/or Sometimes
Psychological Abuse: Did a parent or other adult in the household;	Swear at, insult, or put you down? Act in a way that made you afraid you would be physically hurt? Threaten to hit you or throw something at you but didn't?	Never, once or twice, sometimes, often, very often.	Often Often
Sexual Abuse: Did an adult 5 years older than you:	Touch or fondle you in a sexual way? Have you touched his/her body in a sexual way? Attempt intercourse (oral, vaginal, or anal) with you? Have intercourse (oral vaginal, or anal) with you?	Yes/No	Yes to any question
Witnessing Maternal Battering: Did your father or stepfather or mother's boyfriend ever:	Push, grab, slap or throw something at your mother or stepmother? Kick, bite, hit her with a fist or something hard? Repeatedly hit her over at least a few minutes? Threaten or hurt her with a knife or gun?	Never, once or twice, sometimes, often, very often.	Often and/or Sometimes Once or twice Once or twice
Household Mental Illness Was/did someone in your household:	Depressed or mentally ill? Attempt suicide?	Yes/No	Yes
Household Substance Abuse: Was someone in your household:	A problem drinker or alcoholic? A person who used street drugs?	Yes/No	Yes
Household Criminal Activity:	Did a household member ever go to prison?	Yes/No	Yes
Parental Divorce or Separation:	Were your parents ever divorced or separated?	Yes/No	Yes

POSSIBLE REACTIONS TO TRAUMA

Infant and Toddlers (Ages 3 and under)

- Excessive crying with difficulty consoling
- Searching for parents/caregivers
- Increased clinging behavior separate from Stranger Anxiety
- Change in sleep and eating habits
- Regressive behavior (e.g., baby talk, thumb sucking, bed-wetting, tantrums)
- Repetitive play or talk

Preschoolers and Young Children (Ages 3-5)

- Fear of separating from parents/loved ones
- Increased clinging behaviors
- Increased temper tantrums or irritable outbursts
- Sleep disturbance (e.g., wanting parents, generalized nightmares)
- Regressive behaviors (e.g., wetting, thumb-sucking, baby-talk)
- Withdrawal
- Increase in fears (in general: dark, monsters)

Note: Young children (infants through age 5 years) may be more strongly affected by the reactions of parents or other adults than are school-aged children and adolescents.

Children (Ages 6 to 11 years)

- Regressive behaviors
- Anger, fighting, irritability, bullying, blaming
- Denial/Avoidance/Withdrawal/Social isolation
- Inability to concentrate and focus
- Fears, depression, anxiety, panic (Mood swings)
- Physical complaints (stomach aches, headaches, vague aches and pains)
- Self-blame
- School refusal

Adolescents (Ages 12 to 17 years)

- Responses may be more similar to adults and trauma-specific
- Depression, suicidal thoughts, guilt/shame (Adolescents may have repetitive thoughts about death and dying. These reactions may result in increased risk taking behaviors such as alcohol and other substance abuse, promiscuous sexual behaviors)
- General anxiety, panic attacks, dissociation
- Numbing, re-experiencing
- Mood swings, irritability

- School refusal (or academic decline)
- Concentration difficulties
- Fears: usually event-related (e.g., planes, death) particularly revenge thoughts

Factors to Consider

- Traumatic events experienced before age 11 are three times more likely to result in serious emotional and behavioural problems than those experienced later in life
- The psychological impact of such events tends to persist or become worse with time
- Parents often underestimate the intensity and duration of their children's reaction to stress
- These reactions vary with a child's age, intellectual capacity, personality and social challenges
- The functioning of adults who care for a child has a tremendous effect on the child's capacity to recover
- The trauma nature of a death can complicate bereavement
- The most likely problems are post-traumatic stress disorder and other forms of anxiety, grief and depression, aggressive and defiant behavior, physical symptoms, lowered self-esteem, and social and academic difficulties

TREATMENT ALTERNATIVES FOR CHILDREN WITH PTSD

Educationally-based Interventions (for both child and family members). See cognitive-behavioral Interventions for Trauma in Schools (CBITS) (*See below*)

Behavioral Treatments (Relaxation training, in vivo exposure, self-control and social skills training)

Cognitive-behavioral treatment (Trauma focused CBT; Stress Inoculation Training, Self-Instructional training, Cognitive Restructuring, Problem-Solving, Relapse Prevention -- Involve non-offending parent in treatment of child sexual abuse)

Expressive forms of treatment (Cognitive-behavioral play therapy, art therapy, writing, drama reenactments, music therapy)

Group therapy

Proactive activities and involvement

Pharmacotherapy (to treat persistent arousal symptoms, exaggerated startle response, sleep disturbance and depression). Pharmacotherapy can be combined with cognitive-behavior therapy.

Cognitive Behavior Intervention for Trauma in Schools (CBITS). (www.NCTSNET.org).
 Order from Los Angeles Unified School District. Students and Trauma DVD (\$15).
 For more information contact Dr. Marleen Wong (marleenw@usc.edu), Dr. Lisa Jaycox
 (jaycox@rand.org).

Order from LAUSD

333 South Beaudry Ave
 29 Floor
 School Mental Health Services
 Los Angeles, CA 90017

Reference:

Jaycox, L.H. (2003). Cognitive behavioural interventions for trauma in schools.
 Longmont, CO: Sopris Press.

Stein, B.D. et al. (2003). A mental health intervention for school children exposed to
 violence. JAMA, 290, 603-611.

TREATMENT FLOW-CHART

(Note these are not a lock-step sequence.)

**Develop Therapeutic Alliance (Regain sense of safety and security, validate child's
 emotional reactions rather than discourage or minimize them.)**

Provide information, basic services, education

Collaborative Assessment

Education -- Ongoing

Bolster Coping Skills - In vivo practice

Gradual Exposure - In vivo practice

Cognitive Restructuring Procedures -- correct misconceptions and distortions

Address Possible Revictimization

Relapse Prevention Procedures

Follow-Through and Booster Sessions (as required)

Resilience promoting activities

Engage parents and significant others throughout treatment

TREATMENT OF TRAUMATIZED CHILDREN

(See Cohen, J.A., Mannarino, A.P. & Deblinger, E. (2006). Treating Trauma and Traumatic Grief in Children and Adolescents. New York: Guilford Press. Also see the following websites for training in Trauma-focused Cognitive Behavioral Training and for related materials:

www.musc.edu/fcbt

www.nctsnet.org

TREATMENT PROTOCOL: ACRONYM PRACTICE

P PSYCHOEDUCATION AND PARENTING SKILLS

R RELAXATION SKILLS

A AFFECT MODULATION SKILLS

C COGNITIVE COPING AND PROCESSING SKILLS

T TRAUMA NARRATIVE

I IN VIVO MASTERY

C CONJOINT CHILD-PARENT SESSIONS

E ENHANCING FUTURE SAFETY AND DEVELOPMENT

Also see:

Deblinger, E. & Heflin, A.H. (1996). Treating sexually abused children and their nonoffending parents: A cognitive-behavioral approach. Thousand Oaks, CA: Sage.

Saxe, G.N., Ellis, B.H. & Kaplow, J.B. (2007). Collaborative treatment of traumatized children and teens. New York: Guilford Press.

Smith, P., Perrin, S., Yule, W. & Clark, D.M (2010). Post traumatic stress disorder: Cognitive therapy with children and young people. New York: Routledge.

RESILIENCE PROMOTING ACTIVITIES FOR CHILDREN AND ADOLESCENTS

(See papers by Ann Masten and Don Meichenbaum on resilience on www.melissainstitute.org)

The following activities were suggested by Grothberg (1995) and are described on <http://resilnet.uiuc.edu/library/groth95b.html>. Youth are asked to generate examples under three categories of **I HAVE**, **I AM**, **I CAN**. They can interview and collect examples from significant others in their lives.

I HAVE

- People around me I trust and who love me, no matter what (*Trusting relationship*)
- People who set limits for me so I know when to stop before there is danger or trouble (*Structure and rules at home*)
- People who show me how to do things right by the way they do things (*Role models*)
- People who want me to learn to do things on my own (*Encouragement to be autonomous*)
- People who help me when I am sick, in danger or need to learn (*Access to health, education, welfare and security services*)

I AM

- A person people can like or love (*Loveable and my temperament is appealing*)
- Glad to do nice things for others and show my concern (*Loving, empathetic and altruistic*)
- Respectful of myself and others (*Proud of myself*)
- Learning to be responsible for what I do (*Autonomous and responsible*)
- Sure things will be alright (*Filled with hope, faith and trust*)

I CAN

- Talk to others about things that frighten me or bother me (*Communicate*)
- Find ways to solve problems that I face (*Problem-solve*)
- Control myself when I feel like doing something not right or dangerous (*Manage my feelings and impulses*)
- Figure out when is a good time to talk to someone or to take action (*Gauge the temperament of myself and others*)
- Find someone to help me when I need to (*Seek trusting relationships*)

RESILIENCE TRAINING FOR CHILDREN AND ADOLESCENTS

The following items were used in the International Resilience Project to identify resilience in children and adolescents. (*See* <http://resilnet.uiuc.edu/library/groth95b.html>.)

- The child has someone who loves him/her totally (unconditionally).
- The child has an older person outside the home she/he can tell about problems and feelings.
- The child is praised for doing things on his/her own.
- The child can count on his/her family being there when needed.
- The child knows someone he/she wants to be like.
- The child believes things will turn out all right.
- The child does endearing things that make people like her/him.
- The child believes in a power greater than seen.
- The child is willing to try new things.
- The child likes to achieve in what he/she does.
- The child feels that what he/she does makes a difference in how things come out.
- The child likes him/herself.
- The child can focus on a task and stay with it.
- The child has a sense of humor.
- The child makes plans to do things.

V. Topical Panel 5 Friday Dec . 13 10:40-11:40

POST TRAUMATIC STRESS DISORDERS

With Jack Kornfield, Peter Levine and Mary Pipher

Dr. Meichenbaum will consider :

- 1. the controversies concerning the concept of PTSD and the recent changes in DSM 5 . For example, one can experience the symptoms of PTSD without a Criterion A event, raising issues about causation.**
- 2. the need to tailor interventions to the emotional needs of traumatized clients whose major reactions may not be anxiety warranting exposure-based interventions, but instead they may be struggling with guilt, shame, humiliation, disgust , anger , complicated grief and moral injuries;**
- 3. the " state of the art" of treating clients with PTSD and Complex PTSD and accompanying comorbid psychiatric disorders. He will consider the communalities that cut across the variety of ACRONYM psychotherapies for PTSD.**
- 4. the critical role of the therapeutic alliance in the treatment of traumatized and victimized clients;**
- 5. the value of a Constructive Narrative Perspective of PTSD , or the nature of the " stories" that clients tell themselves and others , in distinguishing between the 75 % who evidence resilience versus the 25 % who evidence chronic PTSD and adjustment difficulties.**

(See www.roadmaptoresilience.org for specific ways to bolster resilience)

THE FOLLOWING RECENT CHAPTER DISCUSSES THESE POINTS IN MORE DETAIL. YOUR REACTIONS ARE WELCOME dhmeich@aol.com.

**THE THERAPEUTIC RELATIONSHIP AS A COMMON FACTOR:
IMPLICATIONS FOR TRAUMA THERAPY**

**Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo, Ontario, Canada**

and

**Research Director of The
Melissa Institute for Violence Prevention
Miami, Florida**

In D. Murphy, S. Joseph and B Harris (Eds.), Trauma, recovery and the therapeutic relationship: Putting the therapeutic relationship at the heart of trauma therapy. London, UK: Palgrave MacMillan.

Here is the challenge. I recently retired from my University to assume the position as Research Director of the Melissa Institute for Violence Prevention (see www.melissainstitute.org). In this capacity, I am invited to consult and train clinicians on ways to work with clients who have experienced traumatic events and victimizing experiences. The clients usually have received a diagnosis of PTSD and an array of comorbid disorders such as substance abuse and depressive disorders. For instance, I have been training clinicians who are working with returning service members, torture victims, Native populations who have been sexually abused, as well as clinicians who work in Residential Treatment Centers. If you were in my shoes, what advice would you offer these clinicians? What specific interventions would you recommend?

Consider the treatment options that can most succinctly be summarized in a list of Acronyms. In fact, I have come to the conclusion that you cannot formulate a treatment for patients with PTSD and related disorders unless you have an Acronym. In fact, I think that therapists must come up with the Acronym first, and then develop the therapy. You can choose from the following list:ⁱ

DTE, VRE, CPT, EMDR, SIT, AMT, MBSR, MAGT, ACT, CR, TF-CBT, IBT, CP, CMT, IPT, IRT, and others.

In addition, you can select from an additional array of treatment approaches that have been developed to address the presence of comorbid disorders like SS, TARGET, and STAIR-MPE.ⁱⁱ This list of treatment options could be extended if we consider specific interventions that address patient dominant emotional concerns like complicated grief, guilt, shame, anger, moral injuries and spiritually-based interventions.

Remember, as a consultant I am getting paid to help psychotherapists choose the “best” most effective interventions. The catch-words are “evidence-based” and “evidence-informed” interventions.

Now, here is the rub. In my desire to be an “honest broker” and not a specific advocate of any one Acronym therapy, I find myself on the “horns of dilemma”. On the one hand there is the report of the Institute of Medicine (2008) of the efficacy of exposure-based therapies with patients who suffer from PTSD, and the Veteran’s Administration endorsing and training their clinical personnel on Direct Therapy Exposure and Cognitive Processing Therapy.

On the other side of the debate, there are a number of meta-analytic reviews that question the relative differential efficacy of so-called “evidence-based therapies” versus bona fide comparison groups that are “intended to succeed.” Reviews by Benish et al. (2008), Imel et al. (2008), Keijsers et al. (2000), Norcross (2002), and Wampold et al (1997, 2010) have seriously challenged the proposition that any one Acronym form of treatment is the “winner of the race” and should be embraced and advocated by me in my consultative capacity. Moreover, Webb et al. (2010) have reported that the therapist’s adherence to evidence-based treatment manuals is not related to treatment outcome. In fact, “loose compliance” that is tailored to the patient’s individual needs may be the best treatment approach.

Such meta-analytic reviews have not gone without their critics, as highlighted by Ehlers et al. (2010). But, keep in mind that the clinicians that I am called upon to train, still want to know specifically what to do with their challenging patients.

For the moment, let us assume that each of the Acronym therapeutic approaches, do indeed, lead to favorable outcomes with patients diagnosed with PTSD and comorbid disorders. What are the common mechanisms that contribute to such patient improvements?

Another way to frame this question is to share an example of my supervisory role of clinical graduate students at the University of Waterloo in Ontario Canada. In our clinic, we had several interview rooms side-by-side, each with one way viewing mirrors. I would sit on a high-backed chair which had wheels and I could roll up and down the viewing corridor watching several students at one time. Okay, so imagine in each clinical interview room you could watch Edna Foa conducting Direct Therapy Exposure, Barbara Rothbaum using amplified Virtual Reality Exposure, Pat Resick conducting Cognitive Processing Therapy, Francine Shapiro conducting EMDR, Marsha Linehan teaching skills in Dialectical Behavior Therapy, and so forth. What makes these psychotherapists effective? What do “expert” therapists do, and not do, that leads to positive treatment outcomes?

In answering this question keep in mind that there is little or no evidence of the “specificity” of treatment effects. Interventions that are designed to alter specific behavioural skill areas do not usually evidence changes in that domain. Moreover, when dismantling treatment studies are conducted, with the key treatment ingredients omitted or altered, favorable treatment results are still evident (see Rosen & Frueh, 2010).

Hopefully, you are beginning to appreciate the source of my challenge. What would you do? My solution has been to identify and enumerate the “Core Tasks” of what underlie treatment improvement. My list is gleaned from both the research literature and my 40 years of clinical work.

Core Tasks of Psychotherapy

What are the core tasks that characterize the performance of psychotherapists who achieve positive treatment outcomes? This question has been addressed from Carl Rogers (1957) initial examination of the necessary and sufficient prerequisite conditions of psychotherapy to Jerome Frank’s (Frank & Frank, 1991) analysis of common persuasive features of behavior change to a search for the “heart and soul” of change by Miller, Duncan and Wampold (2010).

In each instance, a set of common psychotherapeutic tasks have emerged. These tasks are dependent upon the quality and nature of the therapeutic alliance as being central to patient behavioural change. As highlighted by Ackerman and Hilsenroth (2003), Martin et al. (2000), Messer and Wampold (2002), Norcross (2002), Safran and Muran (2002), and Wampold (2001), the quality and nature of the therapeutic alliance accounts for a significant larger proportion of treatment outcome variance than do therapist effects and the specific treatment interventions, or the specific form of Acronym therapy that is being implemented. Approximately one third of treatment outcome is accounted for by the therapeutic alliance, significantly more than does the specific type of therapy (Duncan et al. 2009). The therapeutic alliance relationship is the “cornerstone” of effective therapy (Norcross, 2009). As Irvin Yalom (2002, p. 34), stated, “the paramount task of psychotherapy is to build a relationship together that will become the agent of change.” Walsh, (2011 p. 585) observed that “Ideally, therapeutic relationships then serve

as bridges that enable patients to enhance life relationships with family, friends and community.”

The correlation between the quality of the therapeutic alliance and treatment outcome is approximately .26, which corresponds to a moderate effect size. The pattern of patient participation and the degree of patient therapeutic engagement in the first three therapy sessions is predictive of treatment outcome. Patients with weaker therapeutic alliance are more likely to drop out of psychotherapy (Sharf et al., 2010).

The relationship between the quality and nature of the therapeutic alliance and the treatment outcomes is further strengthened when psychotherapists assess and employ ongoing real-time patient feedback. Lambert and his colleagues (Lambert, 2010; Lambert et al. 2005; Shimokawa, Lambert & Smart, 2010) and Miller et al. (2007) have demonstrated that measuring, monitoring and alerting psychotherapists to potential patient treatment failure on a session-by-session basis by soliciting patient feedback of treatment response maximizes treatment outcomes. Such feedback permits the psychotherapist to individually alter and tailor the intervention to the patient’s needs, and thereby strengthens the therapeutic alliance.

The role of the therapeutic alliance in impacting treatment outcome has now been demonstrated with diverse clinical populations. For example, a meta-analysis of 24 studies of couple and family therapy using a variety of self-report alliance measures (Working Alliance Inventory, Couple Therapy Scale and Family Therapy Alliance Scale) found that the interplay of each family member’s alliance with the therapist was related to treatment retention and outcomes. Patients who reported feeling “safe” within therapy with the avoidance of excessive cross-blaming, hostility and sarcasm in sessions reported stronger therapeutic alliances and better treatment outcomes. In so far as a shared sense of purpose and the establishment of overarching familial systemic goals were achieved, rather than individual goals, therapeutic alliance development and treatment outcome were enhanced. (Escudero et al. 2011; Friedlander et al. 2011). McLeod (2011) conducted a similar meta-analysis of the relationship of therapeutic alliance and treatment outcome in youth psychotherapy, and reported similar relationships.

A different research approach to studying the role of therapeutic alliance in influencing treatment outcome has been to ask patients what they have found helpful and unhelpful on the part of their therapists. Hamilton and Coates (1993) interviewed abused women who offered the following observations of their psychotherapists.

Helpful psychotherapists

“Listened respectfully and took me seriously.”

“Believed my story.”

“Helped me see if I was still in danger and explored with me how I could deal with this situation.”

“Helped me see my strengths.”

“Helped me understand the impact of traumatic events on myself and on others.”

“Helped me plan for change.”

In contrast, unhelpful psychotherapists

“Did not listen and did not have an accepting attitude.”
“Questioned and doubted my story.”
“Dismissed or minimized the seriousness of my situation.”
“Gave advice that I did not wish to receive.”
“Blamed or criticized me.”

A similar profile of patient reactions was reported by Elliot (2008).

Whether one considers the findings of meta-analytic studies or the results of interview studies with patients, the degree to which the patient feels respected, heard, accepted, empathetically understood, validated and hopeful enhances the likelihood of positive treatment outcomes. The felt sense of collaboration between the therapist and patient, including an emotional bond and negotiation of therapy tasks and goals has consistently predicted favorable treatment outcomes (Horvath et al. 2011).

The therapeutic alliance has come to be defined as the extent to which the patient and the psychotherapist jointly agree on the goals of treatment and the means or tasks by which to achieve these goals (“pathways thinking”), and the quality of the affective bond that develops between them (Bordin, 1979; Horvath & Bell, 2002; Norcross, 2002). McFarlane (1994) observes that trust is an essential feature of the therapeutic alliance with traumatized patients. The patient must feel secure and confident that the therapist is genuine, empathetic and warm, and moreover, that the therapist can cope with bearing witness to the patient’s reported trauma and understand its significance. These various authors are highlighting that the therapeutic alliance is the primary “vehicle”, “prerequisite”, “process”, “glue”, that permits patients to develop the courage to avoid avoidance, reexpose themselves to traumatic events, reminders, cues, and reengage life.

Additional Core Tasks of Psychotherapy

If we now revisit the various trauma psychotherapists (Foa, Rothbaum, Shapiro, Linehan and the other Acronym Therapists), what do they have in common? Clearly, one thing is their ability to establish, maintain, monitor the therapist alliance and address any potential “ruptures” accordingly. But they do much more. They each:

1. Assess for the patient’s safety (conduct risk assessment) and ensure that basic patient needs are being met.
2. Educate the patient about the nature and impact of trauma, PTSD and accompanying adjustment difficulties and discuss the nature of treatment. Address issues of confidentiality billing, logistics, and the like. But always conveying a “caring” attitude.
3. Conduct assessments of the patient’s presenting problems, as well as their strengths. What have the patient’s done to “survive” and “cope?” They tap the “rest of the patient’s story.”
4. Solicit the patient’s implicit theory about his/her presenting problems and his/her implicit theory of change. The therapist provides a cogent rationale for the treatment approach and assesses the patient’s understanding. Makes the therapy process visible and transparent for the patient.
5. Alter treatment in a patient-sensitive fashion, being responsive to cultural, developmental and gender differences.

6. Nurture “hope” by engaging in collaborative goal-setting, highlighting evidence of patient, family, cultural and community resilience.
7. Teach intra and interpersonal coping skills and build into such training efforts the ingredients needed to increase the likelihood of generalization and maintenance of treatment effects. The effective therapist does not merely “train and hope” for generalization, but explicitly builds in such features as relapse prevention, attribution re-training, aftercare, putting patients in a consultative mode (or in the “driver’s seat”), so they become their own therapist.
8. Provide interventions that result in symptom relief and address the impact of comorbid disorders.
9. Encourage, challenge, cajole patients who have been avoidant to reexperience, reexpose themselves to trauma reminders, cues, situations and memories. Enlist the support of significant others in these reexposure activities.
10. Teach patients a variety of direct-action problem-solving and emotionally-palliative coping skills (for example, mindfulness activities), to the point of mastery, addressing issues of treatment nonadherence throughout.
11. Help patients reduce the likelihood of revictimization.
12. Finally, engage patients in developing “healing stories.”

In short, whatever the proposed Acronym-based intervention (direct exposure, cognitive reprocessing, self-regulatory emotional controls, and the like), it is critical to remember that such specific interventions are embedded in a contextualized process. How much of the patient change that is achieved in trauma therapy should be attributed to each of these component steps and how much to “manualized” treatment procedures.

Table 1 is the Psychotherapist Checklist I use in my consulting role. This Checklist highlights how to make the so-called “non-specifics” of psychotherapy specific, trainable and measurable. It enumerates ways to enhance therapeutic alliance and treatment outcomes. The importance of these psychotherapeutic skills are highlighted by a better appreciation of the goals of trauma therapy from a Constructive Narrative Perspective.

Constructive Narrative Perspective of the Impact of a Therapeutic Alliance

Most individuals (70%-80%) who have experienced traumatic and victimizing experiences evidence resilience and in some instances, post-traumatic growth (Bonanno, 2004; Meichenbaum 2006, 2007, 2009, 2011, 2012). The 20%-30% of the traumatized population who evidence adjustment difficulties and who are candidates for some form of trauma therapy evidence a cognitive emotional, behavioural and spiritual style that contributes to persistent PTSD. Patients who receive the diagnosis of PTSD are likely to engage in:

1. Self-focused, mental defeating ruminative style of thinking;
2. Avoidant thinking processes of deliberate suppressing thoughts, using distracting behaviors that inadvertently reinforce avoidant behaviors and PTSD symptoms;

3. Overgeneralized memories and a recall style that intensifies hopelessness and impairs problem-solving;
4. Contra-factual thinking, repeatedly asking “Why” and “Only if” questions for which there are no readily acceptable answers;
5. Engage in “thinking traps” that reinforce hypervigilance, safety and emotionally distancing behaviors and that contribute to the avoidance of self-disclosing and help seeking;
6. Negative spiritual coping responses (Having a “spiritual struggle”, anger responses, moral injuries, complicated grief, guilt, shame and the like).

The trauma patients tell others and themselves “stories” that lead them to become stuck. One central goal of trauma therapy, no matter what form it may take is to help patients develop and live a “healing story.” There is a need for patients to integrate the trauma events into a coherent autobiographical account, so the traumatic events are landmarks, but not the defining elements of their accounts. Trauma patients need to develop “redemptive” stories that bolster hope, strengthen self-confidence and indicate that their efforts will bear fruit. Changes in story-telling provide access to new solutions. The patient’s ability to generate a coherent narrative helps to reduce distress and hypervigilance, increases a sense of control, reduces feelings of chaos and unpredictability, and helps the patient develop meaning. Narrative coherence conveys a sense of personal self-efficacy and helps the patient makes sense of what happened and points a direction to the future. Trauma is only one part of an individual’s life, rather than the determinant aspect. Effective trauma therapy helps the patient learn to let the “past be the past”. Patients can learn to disentangle themselves from the influences and lingering impact of traumatic events. In trauma therapy, patients engage in a narrative healing process.

Trauma therapists, no matter which form of Acronym therapy they employ, are in the business of helping traumatized patients become “story-tellers” who can evidence resilience, moving from the 20%-30% group to the 70-80% resilient group. The therapeutic alliance is the framework whereby trauma patients can share their trauma accounts, as well as what they did to survive and cope in the past; bolster their courage to confront, rather than avoid trauma-related situations and remembrances; develop and strengthen coping strategies that foster hope; undertake meaning-making missions and reengage life. Move from being a “victim”, to a “survivor”, to a “thriver.”

In my consultative capacity, I train trauma therapists to become “exquisitive” listeners and help them become collaborators in their patient’s journey to develop “healing stories.” As Stephen Joseph, (2012 p. 43) has observed: “Human beings are story-tellers. We are immersed in stories.” The role of the trauma therapist is to help traumatized patient’s move along this journey of collecting data (results of personal experiments) that will “unfreeze” their beliefs about themselves, others, the world and the future. The therapeutic alliance is the ground in which such growth develops and blossoms (Meichenbaum, 1996, 2007). Its importance to the change process needs to be highlighted, repeatedly.

CHECKLIST OF THERAPY BEHAVIORS DESIGNED TO FACILITATE THE THERAPEUTIC ALLIANCE

1. Convey respect, warmth, compassion, support, empathy, a caring attitude and interest in helping. Be non-judgmental. Listen actively and attentively, and let your patient know you are listening so he or she feels understood.
2. Convey a relaxed confidence that help can be provided and a sense of realistic optimism, but not false hope. Communicate a positive expectancy of the possibility of change. Use phrases like, “As yet”; “So far” and “RE” verbs such as RE-frame, RE-author, RE-engage). Emphasize that your patient can be helped, but it will require effort on both of your parts.
3. Validate and normalize the patient’s feelings. (“Given what you have been through, I would be deeply concerned, if at times you were not feeling overwhelmed and depressed”).
4. Use guided discovery and Socratic Questioning. Use “How” and “What” questions. Stimulate the patient’s curiosity, so he/she can become his/her own “therapist”, “emotional detective”.
5. Enter the narrative text of the patient, using his/her metaphors. Assess the “rest of the patient’s story” and collaboratively discover what the patient did and was able to achieve in spite of traumatic/victimizing experiences.
6. Explore the patient’s lay explanations of his or her problems and his or her expectations concerning treatment. Collaboratively establish “SMART” therapy goals (Specific/Measurable. Achievable, Realistic, and Time-limited). Use motivational Interviewing Procedures.
7. Model a style of thinking. Ask the patient, “Do you ever find yourself in your day to day experiences, asking yourself the same kind of questions that we ask each other here in therapy?”
8. Encourage the patient to self-monitor (collect data) so that he/she can better appreciate the interconnectedness between feelings, thoughts, behaviors and resultant consequences, and perhaps, inadvertently, unwittingly, and unknowingly behave in ways that may maintain and exacerbate presenting problems (e.g., avoidance behaviors reinforce PTSD symptoms).
9. Conduct a pros and cons analysis and help the patient to break the behavioral “vicious cycle.”
10. Address any Therapy Interfering Behaviors and potential barriers. Solicit patient commitment statements. Play “devil’s advocate.”

11. Provide intermediate summaries and a summary at the end of each session. Over the course of treatment have the patient generate this treatment summary. Highlight how the present session follows from previous sessions and is related to achieving treatment goals. Be specific. Have the patient generate the reasons why he/she should undertake behavioral changes.
12. Help patients generate alternative “healing” narratives that empower them to examine their dominant “trauma” story and develop and live personal accounts that contribute to post-traumatic growth.
13. Solicit feedback from the patient each session on how therapy is progressing and ways to improve treatment. Convey that you, the therapist, is always trying to improve and tailor treatment to the needs and strengths of each specific patient. Monitor the relationship for any alliance strains. Accept part of the responsibility for any difficulties in the relationship.

SUMMARY

1. Much effort has been expended to develop evidence-based interventions with patients diagnosed with PTSD and comorbid disorders- - what are called “Acronym Therapies.
2. Exposure-based interventions such as Direct Therapy Exposure and Cognitive Processing Therapy have been endorsed as being most effective.
3. Meta-analytic studies of various so-called “evidence-based” therapies for PTSD patients versus bona-fide comparison groups that were intended to succeed have raised questions about the differential effectiveness of various treatments.
4. Both dismantling and specificity-based studies have questioned the mechanisms of change on those interventions.
5. Common to all these “Acronym” therapies are a set of Core Psychotherapeutic tasks with the most central being the nature and quality of the therapeutic alliance which accounts for the largest proportion of treatment outcome variance.
6. The impact of the therapeutic alliance on treatment outcome is strengthened when ongoing, real-time session-by-session feedback is solicited from patients and used by the psychotherapist to identify potential failures and dropout risk and to alter treatment accordingly.
7. Other core psychotherapeutic tasks beside establishing, maintaining and monitoring therapeutic alliance include psychoeducation, nurturing hope by means of collaborative goal-setting and bolstering resilience, teaching coping skills and building in generalization procedures.
8. Key ingredients in the development of a therapeutic alliance include empathy, trust, respect and a caring attitude. Table 1 provides a list of psychotherapeutic methods to enhance the therapeutic alliance and treatment outcomes.
9. A constructive narrative perspective of the therapeutic alliance highlights how to help traumatized/victimized patients develop “healing stories” with redemptive endings that engender hope, self-efficacy and help move trauma patients (some 20-30% of victimized individuals) to the 70-80% of resilient individuals.
10. The therapeutic alliance provides patients with an opportunity to share, reframe, and develop the courage to reexpose, reexperience, reengage and review their lives so traumatic events are incorporated into a coherent narrative and a personal account.

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¹ DTE-Direct Therapy Exposure; VRE- Virtual Reality Exposure; CPT- Cognitive Processing Therapy; EMDR- Eye Movement Desensitization and Reprocessing; SIT- Stress Inoculation Training; AMT- Anxiety Management Training; MBSR- Mindfulness Based Stress Reduction; MAGT- Mindfulness and Acceptance Group Therapy; ACT- Acceptance and Commitment Therapy; CR- Cognitive Restructuring; TF-CBT- Trauma Focused Cognitive Behavior Therapy; DBT- Dialectical Behavior Therapy; CP- Counting Procedures; CMT- Compassion Mindfulness Training; IPT- Interpersonal Therapy; IRT- Imagery Rehearsal Therapy.

¹ SS- Seeking Safety Treatment; TARGET- Trauma Adaptive Recovery Education and Therapy; STAIR-MPE- Skills Training in Affective and Interpersonal Regulation Followed by Modified Prolonged Exposure.

VI. CLINICAL DEMONSTRATION 13 SAT DEC 14 9:20-10:20**TREATMENT OF A SUICIDAL PATIENT WITH A HISTORY OF VICTIMIZATION: A CONSTRUCTIVE NARRATIVE PERSPECTIVE**

The very first client I ever treated as a clinical graduate student at the University of Illinois died by suicide. In the remaining 40 years of clinical practice, supervision and consultation, there have been several additional clients who have also died by suicide during treatment, or soon after treatment. Thus, client suicide is a topic I have been deeply involved with throughout my professional career.

Please visit the Melissa Institute Website (www.melissainstitute.org) and go to the Home page and click on Author Index on the left side of the Home page. You can scroll down to Meichenbaum and open several related papers .See

"35 years of working with suicidal patients : Lessons learned"

"Help the helpers: Ways to bolster resilience" (Ways of coping with the suicidal death of your client)

"Child and adolescent depression and suicide: Promising hope and facilitating change"

Also see a paper by Joan Asarnow "Assessment of depression and suicide risk: Strategies for matching youths to optimal interventions"

The film that will be shown in this presentation is available from the American Psychological Association .

(SEE PAGES 215-249 OF THIS HANDOUT FOR A DISCUSSION OF TREATMENT APPROACHES FOR SUICIDAL PATIENTS)

**APA PSYCHOTHERAPY VIDEO SERIES I
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Donald Meichenbaum, Ph.D
Hosted by Jon Carlson, PsyD, EdD**

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VII. Point/Counterpoint 9 – ADVANCED TECHNIQUES OF THERAPY: IMPACTFUL INTERVENTION

Presenter Jeff Zeig

Discussant Donald Meichenbaum

**VIII. PRESENTATION BY DR. MEICHENBAUM WED. DEC.11 2013
10:00-11:30**

POINT/ COUNTERPOINT " TRAUMA , SPIRITUALITY AND RECOVERY "

DISCUSSANT : ERVING POLSTER , Ph.D.

In this presentation, Dr. Meichenbaum will discuss:

- 1. how he got from being trained in a behaviorally-oriented clinical training program to discussing ways to integrate spirituality and psychotherapy;**
- 2. research that indicates that the major way traumatized individuals cope is by using some form of spirituality/religion and the implications for treatment;**
- 3. ways to assess for the client's spirituality/ religious beliefs and practices (A client Self-assessment Checklist, as well as a Checklist for 12 Step AA programs are included in this Handout);**
- 4. ways to integrate spirituality into psychotherapy (A psychotherapist Self - assessment Checklist is included in the Handout);**
- 5. the dangers of individuals using spirituality and religious practices as a coping approach;**
- 6. ways to tailor psychotherapeutic interventions in a culturally sensitive fashion.**

Dr. Meichenbaum will show a brief video entitled "Where was God on 9 /11? " to illustrate the challenges of working with clients who use their spirituality and religious beliefs and practices to cope with trauma.

SEE THE FOLLOWING HANDOUT (84 pages) TO ACCOMPANY THIS PRESENTATION

TRAUMA, SPIRITUALLY AND RECOVERY

Donald Meichenbaum, Ph.D.
Distinguished Professor Emeritus,
University of Waterloo
Waterloo, Ontario, Canada
and
Research Director of
The Melissa Institute for Violence Prevention

www.melissainstitute.org
www.teachsafeschools.org
www.roadmaptoresilience.org

Contact Information

dhmeich@aol.com

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215 Sand Key Estates Drive
Clearwater, FL 33767

Books Available

Roadmap to Resilience: A guide for military, trauma victims and their families.
Clinical Handbook - - Treating Individuals with Anger-Control Problems and
Aggressive Behavior.

**ROADMAP TO RESILIENCE: A GUIDE FOR MILITARY, TRAUMA VICTIMS
AND THEIR FAMILIES**

Donald Meichenbaum

(211 Pages Price \$ 35)

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Appendix B: User-friendly Guide of Resilient Behaviors

References

Order Form (See www.roadmaptoresilience.org)

About The Author

**TREATMENT OF INDIVIDUALS WITH ANGER-CONTROL
PROBLEMS AND AGGRESSIVE BEHAVIOR
HOW TO USE THIS HANDBOOK
(COST \$65)**

It is not expected that this HANDBOOK will be read from cover to cover, but rather will be used as a Reference Guidebook like a fine cookbook. The connoisseur will on multiple occasions for suggestive guidelines. But like the “expert” chef, the creativity alter the recipes and procedures to meet his/her needs. In order to fax this referral process, the following list of CONTENT is offered. Also, see the SUBJECT (p.446).

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(For a description of the Door County workshop see

(<http://www.mcw.edu/psychiatry/doorcounty2014.htm>)

(For a description of the Cape Cod workshops see www.neei.org)

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PROLOGUE

How did I come from a very behaviorally-oriented clinical psychology training program (University of Illinois, Champaign, 1962-1966) to exploring ways to integrate spirituality and psychotherapy?

I. By way of Introduction

Populations I have worked with where spirituality and religious practices play a prominent role.

- Trauma survivors and mental health workers (Aftermath of Hurricanes Katrina and Sandy, 9/11 terrorist attacks, Columbine school shooting, Oklahoma City and the Boston Marathon Bombing). Spiritual healing rituals prominent for each population.
- Torture victims in the U.S. from around the world
- Native populations in the U.S. and Canada
- Latino populations in Miami and elsewhere
- Consult residential psychiatric facilities where 12 Step AA programs are central to treatment . Also trained addiction counselors who work with clients who have comorbid psychiatric disorders of PTSD and Substance Abuse.
- Work with Ministers of African American Churches
- Work with Chaplains in the Military
- Present to a variety of clinicians who work with Hasidic Jews, Mormons, Amish, Jesuits
- Present in various countries like Japan, Hong Kong, Caribbean, Hawaii, European countries where religious ceremonial rituals and spiritual beliefs are prominent
- Included spirituality as one of six domains (physical, interpersonal, emotional, cognitive, behavioral and spirituality) in my recent book Roadmap to resilience: A guide for military, trauma victims, and their families.

I. EVIDENCE OF RELIGIOSITY/SPIRITUALITY

North Americans are a very religious and faith-based community. The following statistics offered by Pargament (2007) and Thoresen and Plante (2007) attest to the central role of religiosity. They report on the results of a 2000 Gallup poll which indicates that:

- Over 93% of North Americans believe in God or in a higher power;
- 76% report believing that the Bible is the actual or inspired word of God;
- 60% belong to a local religious group;
- 50% think that religious matters are important or very important in how they conduct their lives;
- 40% attend religious services almost weekly or more;
- 80% are interested in “growing spiritually”
- Only 11% report religion to be unimportant to them

The results of a General Social Survey (2007) provide further evidence that religion and spirituality play a central role in many people's lives.

- 30% of adults pray daily and 80% pray when faced with serious problems, crises or health concerns;
- 64% report that they read the Bible or other inspirational literature on a regular basis;
- 70% believe in some form of afterlife;
- 45% report that they definitely believe in the devil and another 20% state they probably do;
- 43%-60% of people who have emotional problems turn first to their clergy for help.

Rose et al. (2001) report that 55% of psychotherapy clients wanted to discuss spiritual or religious issues with their psychotherapist, but only 22 % did so. The decision to raise spiritual issues was influenced by the

- a) client's appraisal of the judged relevance of their faith to reasons for seeking treatment
- b) client's perception of the psychotherapist's openness to such faith-based issues; ("Did the psychotherapist extend an invitation to raise spirituality issues?")

In addition, among some minority groups and Native populations they employ a "**Calling back the spirit**" which refers to their acknowledging and remembering their ethnic, cultural, historical and spiritual roots.. "Calling back the spirit" contributes to their feelings of being "cosmically connected" and feeling "whole".

In considering these statistics it is important not to confuse spirituality and religion. Not everyone who reports being spiritual considers themselves religious and not all who are religious consider themselves spiritual. **Spirituality** refers to an attempt to seek meaning,

purpose and a direction of life in relation to a higher power, universal spirit or God. Spirituality reflects a search for the sacred and refers to "a person's individualized,

internal, value-based connection to the transcendent" (Pargament et al. 2007). Spirituality may or may not be associated with religious practices. For vast majority of the general population, spirituality is expressed in a religious context.

The word **Spirituality** is derived from the Latin word **Spirale** which means **to blow or to breathe**. The Hebrew word "Ruach" and the Greek word "Pneuma" convey a similar meaning. Thus, spirituality denotes giving breath and hope to individuals, families and communities. In contrast, **religion** refers to a form of social institution with its organized set of rules, accompanying beliefs, practices, symbols and rituals. Religion implies an explicit affiliation with religious institutions, as well as adherence to specific dogma, rituals and practices. Viktor Frankl provided the definition that religion reflects a belief in a "final meaning."

Fowler (1995) has proposed that there are changes in how individuals and groups develop their religious beliefs, namely:

Preconventional Form which is unreflective and a literal acceptance of culturally provided beliefs.

Synthetical-conventional Form whereby people begin to create their own individual religious beliefs, that synthesizes diverse conventional beliefs, but it is still largely unreflective.

Post-conventional Form by which individuals reflect on conventional assumptions and they open themselves to multiple perspectives, confront paradoxes and develop concerns and extend their care to people of other faiths.

It is important to note that mental health workers (psychiatrists, clinical psychologists, social workers) often do not attribute the same importance to religion and spirituality as do their clients. Whereas, 9 out of 10 Americans consider religion to be very to fairly important, only 56% of psychiatrists and 48% of psychologists endorse these levels of religious importance (Shafranske, 2000).

II. TRAUMA, SPIRITUALITY AND RECOVERY

"The empirical literature points to a clear conclusion: spirituality is part and parcel of the human response to trauma and its resolution" (Pargament et al., 2006, p. 132).

Religion can play a significant role in helping people to cope with stress or to protect against stress. For many, if not most, when disaster or trauma strikes, it is religion, ritual and faith/spirituality that is embraced as a central means of coping (Bergin, 1983; Gartner et al., 1991; Meichenbaum, 1994). Consider the following examples:

- A National survey conducted by Schuster et al. (2001) found that after the terrorist attacks of September 11, 2001, 90% of Americans reported that they turned to prayer, religion or some form of spiritual activity with loved ones in an effort to cope;
- Following Hurricane Katrina, 92% of those who survived and who were evacuated to shelters in Houston said that their faith played an important role in helping them get through (www.kff.org/newsmedia/7401.cfm);
- When a tornado struck a small southern town in Piedmont Alabama, destroying a church filled with parishioners and killing several children, including the minister's four-year-old daughter, the survivors struggled with such questions as "Why? Why a church? Why those little children? Why? Why? Why?" The minister and parishioners commented that while:

"Their faith is shaken, it is not the same as losing it. Events like this only strengthen our faith... Our faith is an anchor in a turbulent sea... Those who die inside a church will find the gates of heaven open wide.... As long as we have faith, we are strong. No matter how dark it is, if I have faith, I have a song in the night.... Our beliefs are trembled and bent, but they did not break.... There is no reason. Our faith is not determined by reason. Our faith is undergirded by belief, where there is no reason."
(Meichenbaum, 1994, p545)

Many other examples could be offered of how victims who have experienced natural and man-made traumatic events have used their religious beliefs, faith and spiritual means of coping. A most poignant account is offered by Pargament (2007) who describes how prisoners in concentration camps secretly continued engaging in religious activities. Elie Weisel (1965) in his book *Night* describes how God was put on trial by the prisoners of a concentration camp. They found God guilty as charged, but then the prisoners went on to pray anyway.

Another example is offered by McIntosh, Silver and Wortman (1993) who found that religious parents coped better with infant death than nonreligious parents. McIntosh et al. proposed that such better coping was mediated through social support, cognitive processes and the ability to find meaning.

Pargament et al. (2006) report on a 14-year-old Maryland boy who was shot and nearly killed by a sniper, told a packed courtroom that the terrifying experience "brought

me closer to God". This is consistent with the research finding that a number of people who have experienced trauma feel they have grown spiritually or become more religious.

Consider the role that spirituality played in the following account:

" I was a 17 year old suicidal patient hospitalized for 26 months , at times confined to an isolated seclusion room because I engaged in self-injurious behaviors (burning my wrists with cigarettes , slashing my body , head banging)."

"I had to tell my story . I owed it to others. I cannot die a coward ."

" One night I was kneeling in PRAYER , looking up at a 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."

This biographical account was offered by the Distinguished Psychologist Dr. Marsha Linehan, the founder of Dialectical Behavior Therapy (New York Times , June 23,2011)

III. FUNCTIONS OF SPIRITUAL RITUALS

Several major meta-analytic reviews have been conducted that demonstrate that individuals who use religious and spiritual coping efforts demonstrate greater physical and emotional well-being (Ano & Vasconcelles, 2005; Gall et al., 2005; Miller & Kelley, 2005; Miller & Thoresen, 2003; Pargament, 2007). Religious coping has been found to have a significant association with a variety of adjustment indicators including lower levels of depression and alcohol consumption, fewer somatic complaints, fewer interpersonal problems, lower mortality, and greater levels of life satisfaction, more use of social supports and overall improved coping ability (Mc Cullough et al., 2000; Paloutzian & Park, 2013; Powell et al., 2003).

There has been much discussion about what are the mechanisms and processes that contribute to the benefits of engaging in religious and spiritual acts (Cacioppo et al., 2005; Davis et al., 2000; Falselt et al., 2003; Gall et al., 2005; Koenig et al., 2001; Meichenbaum, 1994; Pargament, 2007; Pennebaker, 1997; Snyder, 2000; Spilka et al., 2003). The proposed mechanism include the following:

1. **Encourage non-negative thinking**
2. **Normalize reactions**
3. **Encourage the sharing of emotional expression**
4. **Convey a sense of control and mastery**
5. **Foster social connectedness**
6. **Promote group cohesiveness**
7. **Encourage shared grief work**
8. **Offer closure and nurture hope**
9. **Nurture meaning-making**
10. **Provide guidance**
11. **Bolster resilience**

Let us briefly consider each of these functions of spiritual and religious rituals.

1. Individuals who have been victimized often describe themselves in negative self-disdaining terms that can become self-fulfilling prophecies. As a result of experiencing a traumatic event, victims may convey that they feel:

“dirty, contaminated, desecrated, polluted, worthless, unlovable, stupid, emptied, as if I fell into a bottomless pit.”

“I’m dead inside. I am an emotional orphan. Feel stagnated. I am carrying too many battle scars.”

“I feel this is God’s punishment for my sins. God has abandoned me. I am all alone, a burden to others.”

Such expressions of feeling permanently scared and damaged and mentally defeated contribute to the absence of the ability to engage in mental planning and adaptive coping. Ehlers and Clark (2000) highlight that

traumatized individuals who evidence persistent PTSD have an inability to develop a coherent recounting (narratives) of their trauma experiences.

One outcome of engaging in spiritual coping activities is to reduce the likelihood of victimized individuals engaging in such “negative, self-disparaging, stress-engendering” story-telling to oneself and to others. One’s faith and participation in religious rituals give a person a sense of being loved and valued, exactly as one is, despite a person’s self-image as being “damaged, sinful, abused, abandoned.” As I have discussed elsewhere (Meichenbaum, 2006a, b; 2012), a major goal of interventions is to help individuals engage in **non-negative thinking** and **develop a coherent narrative**. How do spiritually-based activities help to accomplish this goal? Spiritual and religious activities can act to:

2. normalize reactions and internal spiritual struggles;
3. encourage emotional expression, emotional control and emotional comfort by fostering self-disclosure and sharing. (*Pennebaker, 1997 has highlighted the benefits of “opening up” and sharing accounts of trauma, instead of keeping them “secret.”*)

A number of observers have discussed the relationship between emotion-regulation and religion (see Corrigan et al., 2000; Emmons, 2005; Pizarro & Salovey, 2002; Nhaat, 2001; Watts, 2007). Religious practices such as a) prayer which is an exercise in religious reframing, b) meditation and mindfulness activities that can reduce arousal; c) acceptance and forgiveness activities that control negative emotions like anger, guilt and shame, as well as nurture empathy, have each been found to help individuals cope with trauma.

4. convey a sense of “control” and “mastery” that helps people feel that they are not mere victims of arbitrary events in which “bad thing happen to good people” or that “good things happen to bad people”. A belief in a “higher power” who is perceived as being in control implies less arbitrariness in what happens.
5. foster social connectedness with fellow congregants, clergy and with a higher power or deity. Participation in a faith community can help a victim find ways to create blessings from his/her tragedy. This is not to minimize the tragedy or make it seem salutary or beneficial. Rather, through such activities as sharing one’s story with others and/or ministering to others who face a similar situation, one has the opportunity to see that blessings can come from hardship and adversities. (*Cacioppo et al., 2005 have reviewed the research literature that sociality, spirituality and meaning-making are central features of human beings and that relational and collective connectedness combat feelings of isolation and loneliness and that they are critical to the healing process. Socially connected individuals are more likely to meet the demands of everyday stressors by means of active coping and by recruiting help from others.*)
6. promote group cohesiveness, connection and a sense of communion, both with the past and the present.

As Cacioppo et al., 2005 also observe, “*socially connected individuals are more likely to behave in a selfless fashion reinforcing their connections to others and enhancing their self-esteem. Socially isolated individuals are more likely to act in a socially protective and self-deflating manner. Social isolation and accompanying loneliness can have negative physiological consequences (increasing sympathetic activation and contribute to sleep disturbances that can exacerbate stressful reactions)*”.

To underscore Cacioppo et al.’s point, Ano & Vasconelles (2005) and Pargament (2007) have reviewed the literature on the significant health benefits and mental and spiritual well-being associated with the use of spiritual coping efforts. They report that such spiritual coping is particularly helpful for people with poorer and less available personal and social resources who live in trying situations and who are more likely to be members of minority groups, the elderly, less educated and of lower socioeconomic status and who feel insecure and isolated.

The importance of religiosity, as reflected by church attendance, has been found to act as a buffer or protective factor against the development of adolescent juvenile delinquency, even when developing such youth live in a highly disordered neighborhoods. Such a commitment to religious beliefs and practices has been found to reduce the likelihood of antisocial behaviors (Johnson et al., 2001).

7. provide opportunities for public expressions of shared grief and mutual support and reassurances that victims’ sacrifices and lives will be remembered, honored and commemorated. As Elie Weisel (1960) observed:

“I belong to a people whose suffering is the most ancient in the world. I belong to a people whose memory keeps the suffering alive. Just as all days were created for one day alone, the Sabbath, all other words were created and given for one word alone. Remember!”

Traumatic memories are not obstacles to be obliterated, removed, escaped from (for these effort will fail), but these memories are a bridge from the past to the present and the future. Memories are not to be forgotten, but to be contained and sanctified. Jeffrey Jay (1974), in a thoughtful article, “Walls for wailing”, highlights the need for traumatized individuals to “**move toward memory**”, rather than “move beyond memory”. Thou shalt remember, thou shalt seek an accounting! Jay also advises:

“One must have the courage of memory because through it, one can seek God.”

Discussed below are additional metaphors offered by Jay and others on how psychotherapists can incorporate spirituality into their practice.

8. offer a degree of closure on a painful period and encourage transition behaviors to engage in new adaptive activities and nurture hope. As Snyder (2000) observes:

"There is a need to nurture hope and optimism that leads to engaging in goal-directed behaviors and embracing positive strivings and visions. Encourage access to inner strengths, empowerment, control and acceptance".

One's faith conveys hope and a sense of mastery. People can have some control over their lives, hope that they can find a way to give their experience some meaning, and hope that in spite of tragic events, life is not over and can improve.

9. nurture meaning-making in the face of misfortune. As Gall et al. (2005, pp 95-96) observe:

"If a higher power is perceived to be at work in a stressful event, then the event may be viewed as an opportunity to learn something that this higher power is trying to teach. The event may also serve as a 'wake-up call' to take stock of life and rearrange priorities"

Such efforts at meaning-making can provide a sense of relief, comfort, security and a sense of belonging. Placing one's faith and trust in a "just and loving God" can provide traumatized individuals with a "supportive partner" and a "personal confidant." It can help preserve a belief in a Just world.

10. provide guidance in the form of coping models. The Bible, the Torah, the Koran and other holy scriptures can be viewed as "inspirational self-help books", providing guidelines on how to cope with stress.

The use of these spiritual forms of coping may prove most helpful for handling those aspects of stressful situations that cannot be personally controlled, nor changed, and that are not amenable to direct-action problem-solving coping efforts. A good example of such guidelines is offered by Rabbi Harold S. Kushner in his 1981 book, When bad things happen to good people. Consider the following examples:

**Quotable Quotes from Harold S. Kushner's
"When Bad Things Happen To Good People"
New York: Schocken Books, 1981**

"The first thing prayer does for us is put us in touch with other people, people who share the same concerns, values and dreams." (p. 199)

"Prayer reminds us that we are part of a community." (p. 120). "Prayer ... redeems people from isolation." (p. 121)

"If you don't believe in God, why do you go to synagogue so regularly? ... Jews go to synagogue for all sorts of reasons. My friend Garfinkle, who is Orthodox goes to talk to God. I go to talk to Garfinkle." (p. 122).

"They pray as a way of talking out their fears without the embarrassment of having to say them out loud, and as a reassurance that they are not alone." (p. 128).

“In your desperation, you opened your heart in prayer, and what happened? You didn’t get a miracle to avert a tragedy. But you discovered people around you, and God beside you, and strength within you to help you survive the tragedy. I offer that as an example of a prayer being answered.” (p. 131).

“The most anyone promised us was that we would be able to draw upon a source outside ourselves for the strength and courage we would need to survive life’s tragedies and life’s unfairness.” (p. 133).

“The question we should be asking is not, why did this happen to me? What did I do to deserve this? That is really an unanswerable, pointless question. A better question would be, ‘Now that this has happened to me, what am I going to do about it?’” (p. 136, emphasis added)

“We need to get over the questions that focus on the past and on the pain – ‘Why did this happen to me’ and ask instead the question which opens the doors for the future, ‘Now that this has happened, what shall I do about it?’” (p. 137, emphasis added)

“There is one thing we can still do for those we loved and lost. We could not keep them alive. Perhaps, we could not even significantly lessen their pain. But the one crucial thing that we can do for them after their death is let them be witnesses for God and for life. The dead depend on us for their redemption and their immortality.” (p. 138, emphasis added)

“There is a need to see the tragedy in the context of a whole life, keeping one’s eye and mind on what has enriched you and not only on what you have lost.” (p. 139)

“Human beings are God’s language.” (p. 140)

“I would say that God may not prevent the calamity, but He gives us strength and the perseverance to overcome it.” (p. 141).

“Doesn’t God plant in me a little bit of his own divine outrage at injustice and oppression, just as he did for the prophets in the Bible? ... Our responding to life’s unfairness with sympathy and with righteous indignation, God’s compassion and God’s anger working through us, may be the surest proof of all of God’s reality.” (p. 143)

“In the final analysis, the question of why bad things happen to good people translates itself into some very different questions, no longer asking why something happened, but asking how we will respond, what we intend to do now that it has happened.” (p. 147)

“The ability to forgive and the ability to love are the weapons God has given us to enable us to live fully, bravely and meaningfully in this less-than-perfect world. (p. 148, emphasis added)

11. bolster resilience. Most people, especially those of color use their spirituality to enhance their resilience. The belief that things happen for a reason, as well as cultural belief in destiny, fate and karma help individuals accept that which cannot be changed. Participating in spiritual ceremonies increases and reaffirms ethnic identity strengthens and increase resilience. Finding meaning in adversity and espousing a sense of purpose also facilitates coping. The following examples illustrate ways that adverse and traumatic events can be reframed using spiritual and religious beliefs.

“Bad times provide us with an opportunity to know God in ways blessings can never provide.”

“When God seems absent from us, He is doing His deepest work in us.”

“Shattered dreams are God’s unexpected pathway to joy.”

“When painful experiences enter our lives, we can become ‘better’ people or ‘bitter’ people.”

“The Bible encourages us to grow and see the positive side of suffering.”

“Trials and tribulations God uses as the raw material to prune us and help us grow.”

“Adversity teaches us valuable lessons in living.”

The following Summary Tables taken from Roadmap to resilience (Meichenbaum, 2012) highlights the different behaviors and narratives that distinguish individuals who develop persistent PTSD and accompanying adjustment problems versus those who evidence resilience and post-traumatic growth events. Religious and spiritual activities reduce the likelihood of doing the first stress-engendering behaviors and increase the likelihood of engaging in stress-engendering behaviors.

“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

If we can determine what factors contribute to persistent and chronic PTSD and related adjustment difficulties, then we can figure out what leads individuals to get “stuck.” We can then determine how to help these individuals get “unstuck” and develop RESILIENCE. Let us consider what factors come into play at the cognitive, emotional, behavioral and spiritual levels. HOW MANY OF THESE ACTIVITIES DO YOU ENGAGE IN?

At the Thinking Level

Engage in self-focused, “mental defeating” type of thinking. Perception that one has lost autonomy as a human being, lost the will to exert control and maintain identity, lost the belief that one has a “free will.” See self as a “victim”, controlled by uninvited thoughts, feelings and circumstances, continually vulnerable, unlovable, undesirable, unworthy. Use dramatic metaphors that reinforce this style of thinking. “I am a prisoner of the past”, “Entrapped”, “Contaminated”, “Damaged goods”, “A doormat”, “An outsider.” Experience a form of mental exhaustion, mental weariness.

Hold erroneous beliefs that changes are permanent, the world is unsafe, unpredictable and that people are untrustworthy. Hold a negative, foreshortened view of the future and the belief that life has lost its meaning.

Engage in self-berating, self-condemnation, self-derogatory “story-telling” to oneself and to others (i.e., self blame, guilt-engendering hindsight, biased thinking; anger-engendering thoughts of viewing provocations as being done “on purpose”).

Engage in upward social comparisons, so one compares poorly in one’s coping abilities. Be preoccupied with what others think of you. Engage in comparison of self versus others; before versus now; now versus what might have been.

Ruminate repeatedly, dwell on, focus upon, brood, pine over losses, “near miss” experiences. Replay over and over your concerns about the causes, consequences and symptoms related to negative emotions and losses. Use repetitive thinking cycles (“loss spiral”). Hold the belief that you cannot do anything to control such thoughts. (“My thoughts are like a movie that never stops.” “This is like a form of self-punishment that I deserve.”) Focus on your regrets.

Engage in contra-factual thinking, repeatedly asking “Why me” and “Only if” questions for which there are no satisfactory answers.

Engage in avoidant thinking processes of deliberately suppressing thoughts, using distracting behaviors, using substances; avoidant coping behaviors and dissociation (“spaced out” behaviors). Fear your memories and accompanying feelings and engage in avoidant behaviors. Fail to challenge your fears, nor “invite them to tea.”

The more one attempts to suppress cognitive material, the more that material intrudes into consciousness, like a boomerang rebound effect. The act of avoiding traumatic memories given their aversive qualities, the more they intensify in the form of reexperiencing symptoms,

particularly intrusive memories, flashbacks and nightmares.

Have an overgeneralized memory (scattered and lacking coherence) and recall style which intensifies hopelessness and impairs problem-solving. Difficulty remembering specific positive experiences. Memories are fragmented, sensory driven and fail to integrate traumatic events into autobiographical memory or narrative. Let the traumatic events define who you are.

Engage in “thinking traps”. For example, tunnel vision as evident in the failure to believe anything positive could result from trauma experience; confirmatory bias as evident in the failure to retrieve anything positive about one’s self-identity; or recall any positive coping memories of what one did to survive, or what one is still able to accomplish “in spite of” victimization; do mind-reading, overgeneralizing, personalizing, jumping to conclusions, catastrophizing; “sweating the small stuff” and emotional reasoning such as viewing failures and lapses as “end points.”

Evidence “stuckness” in one’s thinking processes and behavior. Respond to new situations in post-deployment settings “as if” one was still in combat (misperceive threats).

At the Emotional Level

Engage in emotional avoidance strategies (“Pine over losses”, deny or shift your feelings, clam up, bury your emotions and do not consider the possible consequences of doing so).

Magnify and intensify your fears and anger.

Experience guilt (hindsight bias or Monday quarterbacking), shame, complicated grief, demoralization, loss of hope.

Fail to engage in grief work that honors and memorializes loved ones or buddies who were lost.

Fail to share or disclose feelings, fail to process traumatic memories. Focus on “hot spots” and “stuck points.”

At the Behavioral Level

Engage in avoidant behaviors of trauma-related feelings, thoughts, reminders, activities and situations; engage in dissociating behaviors.

Be continually hypervigilant, overestimating the likelihood and severity of danger. Act as if you are on “sentry duty” all the time. Act like a faulty smoke detector that goes off at the slightest signal.

Engage in safety behaviors that interfere with the disconfirmation of emotional beliefs and the processing (“restorying”) of trauma-related memories and beliefs.

Engage in delay seeking behaviors. Avoid seeking help. Keep secrets, stuff feelings and be stubborn and rigid.

Engage in high risk-taking behaviors; chasing the “adrenaline rush” in an unsafe fashion;

Put self at risk for revictimization.

Engage in health-compromising behaviors (smoking, substance abuse as a form of self-medication, lack of exercise, sleep disturbance that goes untreated, poor diet, dependence on energy drinks, abandonment of healthy behavioral routines).

Engagement in self-handicapping behaviors (“excuse-making”).

Use passive, disengaged coping behaviors, social withdrawal, resigned acceptance, wishful thinking and emotional distancing.

At the Social Level

Withdraw, isolate oneself, detach from others.

Perceive yourself as being unwanted, a “burden”, thwarted belongingness, distrusting others. (“No one cares”, “No one understands”. “No one can be trusted”).

Associate with peers and family members who reinforce and support maladaptive behaviors. Put yourself in high-risk situations.

Have family members who are “enablers” and who protect you from exposure situations that can combat your avoidance behaviors and who make excuses for you, or who inadvertently, unwittingly, and perhaps unknowingly, reinforce your maladaptive behaviors.

Experience an unsupportive and indifferent social environment (i.e., individuals who are critical, intrusive, unsympathetic and who offer “moving on” statements such as “You will get over this. Time heals everything.”)

Fail to seek social support or help, such as peer-related groups, chaplain services, or professional assistance.

At the Spiritual Level

Fail to use your faith or religion as a means of coping.

Have a “spiritual struggle” and view God as having punished and abandoned you.

Use negative spiritual coping responses. Relinquish actions to a higher power, plead for miracles, or divine intervention; Become angry with God; Be demanding.

Experience “moral injuries” that compromise values. Lose your “moral compass” and “shatter” your deeply held beliefs in safety, trust, self-worth; experience a “soul wound.”

Avoid contact with religious members who can be supportive.

“HOW TO” CREATE A HEALING STORY

One of the things that differentiates us from animals is the fact that we can listen to other people’s stories and they in turn can listen to ours. We can even tell ourselves stories. Instead of calling our species Homo Sapiens, we would be better characterized as “Homo Narrans”- - the story-telling species.

Every year of our lives, we add well over half a million minutes to our banks of experience. How we organize, chronicle, interpret, imbue them with meaning, share these experiences and weave them together into “stories” will influence how RESILIENT we become.

We don’t just tell stories, stories tell us. The tales we tell hold powerful sway over our memories, behaviors and even identities. Stories are fundamental to our being. Once you tell a story, it is hard to get out of that story’s framework. Overtime, the stories we tell tend to get more dramatic. The stories we tell others and to ourselves grip our imagination, impregnate our hearts and animate our spirit.

As human beings we are story tellers, but beware of the stories you tell, you will be lived by them.

There is a “metamorphosis of speech.” The stories that we hear from others turn into conscious inner speech, and then they in turn, become implicit, automatic, unconscious scripts and beliefs that guide and influence our behaviors. Like a pupa that turns into a caterpillar that turns into a butterfly that gives flight, the stories we tell ourselves and others have also been transformed.

1. Following exposure to traumatic events, up to 30% of individuals may evidence chronic distress, and even develop Post-traumatic Stress Disorder and related adjustment problems. Their memory accounts are usually brief, skeletal, fact-oriented, journalistic without emotional depth. Their memories are often fragmented, insufficiently elaborated, details may be missing, lacking coherence of a beginning, middle and end, made up of bits and pieces. Their memories are also over-generalized (lacking in detail) that intensify their sense of helplessness and hopelessness and impairs their problem-solving abilities. Their traumatic narrative is inadequately integrated into their autobiographical memories. Their stories have an inflated sense of responsibility with accompanying excessive guilt and shame. They misperceive their distressing reactions as signs that they are “going crazy” and that they are “worthless” and that they are a burden on others. Their stories convey the belief that the world is unsafe and unpredictable, unjust, and that people are unappreciative of their sacrifices, untrustworthy and unsympathetic. They may feel marginalized, isolated, alienated and rejected.

For those who continue to struggle with the aftermath of the experience of traumatic and victimizing events, their trauma-related memories are viewed as being unwanted, uninvited and involuntary, poorly controlled, nor accepted. The trauma memories are mainly cue-driven so that any stimuli that resemble those that occurred surrounding

the traumatic events can trigger reexperiencing symptoms and accompanying distressing feelings. The individual may act as if the threat is still present and reexperience it as if it was happening right now, rather than being a memory from the past. Such intrusive thoughts and accompanying intense feelings have been characterized like an “unwanted roommate” who keeps showing up and you can’t get rid of him or her. The more you try, the more bothersome the roommate becomes. But, the more you try to avoid and stop him/her, the more bothersome he/she becomes.

In their attempt to stop or suppress such thoughts and feelings, and in their efforts to avoid reminders, they may paradoxically experience even more intrusive distressing thoughts, images and intense feelings and urges. Their coping efforts at suppressing actually **BACKFIRE** and act like a **BOOMERANG**. They may try to cope by self-medicating (using alcohol, drugs), by trying distraction or engaging in high-risk reckless behaviors (withdrawing, isolating themselves, being hypervigilant, on “sentry duty” all the time) and by engaging in “safety behaviors” - - constantly checking and rechecking and engaging in avoidant behaviors. But, such avoidant thinking and behaviors about the traumatic events prevents individuals from processing and incorporating such events into their life stories. It precludes them from obtaining corrective information that may help change any mistaken beliefs that may hold. Such avoidant behaviors prevent them from rebuilding their basic beliefs about themselves, the world and the future. In short, inadvertently, unwittingly, and perhaps, even unknowingly they make their level of distress even worse. Research indicates that the more individuals attempt to tamp down such unwanted thoughts, or when they try intentionally not to think of something, it has the opposite effect. One part of our mind does avoid the forbidden thought, but another part “checks in” every so often to make sure the thought is not coming up - - therefore ironically bringing it to mind.

2. **In contrast, RESILIENT** individuals are psychologically agile and flexible in how they tell their stories. They view the traumatic events as being time-limited experiences that do not necessarily have negative implications for the future. They view their reactions such as intrusive recollections, sleep disturbance, nightmares, difficulties concentrating and the like as a normal part of recovery that follows from upsetting events. When **RESILIENT** individuals tell their stories they include examples of what they did and how they coped and survived. They tell the “rest of their story.” They weave into their story-telling the upside of what happened, as well. They view any traumatic events that they experienced as a “turning point”, a “fork in the road”, a “temporary detour” on their personal life journey. Their stories are rich with healing metaphors, mottos, and examples of pain, but also survival. The metaphors that individuals use serve as a guide to their actions. Consider the differences and impact of individuals calling themselves “victims,” or “prisoners of the past,” or “walking time bombs,” “emotional zombies,” as compared to “survivors,” or “thrivers.” What metaphors do you incorporate in your story-telling?
3. Even though it is emotionally painful, **RESILIENT** individuals are able to process their trauma-related memories, rather than avoid them. They are able to metaphorically “pack away” their memories as if they were “emotional luggage” or “file” them away as in a filing cabinet or cupboard. Resilient individuals can learn to

choose when they open and close the valise, filing cabinet or cupboard. They are able to develop voluntary and deliberate control over their memories, as they repack and reorder their “emotional luggage.” By incorporating these trauma memories as part of their reconfigured and reauthored stories, they are able to place what happened in a broader autobiographical context. Not sharing such accounts, “claming up,” only makes things worse.

Resilient individuals feel more in charge of how they tell and share their traumatic material. They can choose when, where and how they share their experiences. They tell their “stories”. Their stories do not tell them.

Stories are the means by which coping processes exert their influence. Retelling stories to supportive others allows individuals to generate “new stories” about who they are, what role trauma played in their lives and how these events fit into their future plans.

Story telling permits you to look at past events through a different set of lenses and helps you develop a new outlook so the trauma memories will come to elicit less distress, fear, sadness, guilt, shame, and anger. **REMEMBER**, it is not that one experiences such feelings, but what one does with these emotions that determines the level of recovery, resilience and personal growth.

4. Resilient individuals may take some time to experience grief or unhappiness, distress, anger and loss, sadness and anxiety, guilt and shame which improves their abilities to better appreciate the world in all of its complexity and richness.
5. Resilient individuals tend to tell stories that have redemptive sequences in which bad events have good outcomes, as compared to contamination sequences when the reverse happens.
6. Resilient individuals slow down how they tell their stories and break their experiences into pieces. They examine the pieces in terms of all the complexities and then they connect the dots. They do not act like a “Monday morning quarterback,” who has hindsight bias, blaming themselves for things they did not know at the time.
7. Resilient individuals are on the lookout for unexplored “open spaces” in their narrative that act as a guide to new goals and alternatives. Redemption stories bolster hope, strengthen self-confidence that their efforts will bear fruit. They strengthen the belief in the possibility of positive outcomes. Changes in story-telling provide access to new solutions.
8. Resilient individuals tend to tell **COHERENT STORIES** that create meaning out of their stressful life experiences and in which they see themselves as “personal agents” often with the assistance of others, of the positive changes that they have been able to bring about. These **COHERENT NARRATIVES** are clearly articulated, detailed, logical and well organized. Such **COHERENT** stories are salutary and help reduce distress. They increase the survivor’s sense of control over his or her experiences, reduce feelings of chaos and increase the sense that the world is predictable, orderly and beneficent. Coherent story-telling can provide a degree of “closure” by helping

make sense of what happened and how people responded. Narrative coherence conveys feelings of personal self-efficacy and points a direction to the future. It is not enough to help individuals create a trauma narrative, but it is also essential to help individuals integrate such thoughts and feelings into a consistent coherent meaningful experience and story. Trauma is only one part of an individual's life, rather than the defining aspect.

9. Resilient individuals have the ability and penchant to tell their fragmented stories in a chronological narrative with before, middle and post-trauma exposure or post-deployment parts. They are able to integrate what happened during deployment into their autobiographical memory and let the "past be the past." As one Resilient individual stated: "I have no interest in going back to the past and getting stuck again." Resilient individuals refuse to allow the "trauma stories and images" to become dominant in their narrative and take away their sense of identity. They can disentangle themselves from the influence and lingering impact of traumatic events. They engage in a narrative healing process.
10. Resilient individuals avoid "thinking traps" that can derail their story-telling (*See item 64 in the Roadmap to resilience book*). Instead, they incorporate in their story-telling "cherished recollections", "fond memories", a "heritage of remembrances", "change talk" (*See item 65*), "RE-verbs", (*See item 62*). Resilient individuals tell stories that enrich their lives and help them get past their personal challenges. They tell stories that they can pass onto the next generation, as "lessons learned."
11. Resilient individuals tell their stories first and then they live their way into them. They may act "as if" they are characters in the stories that they tell. There may be a certain amount of "fake it, until you make it."
12. Resilient individuals are "thought detectives", noticing when they are falling into "thinking traps" and engaging in "negative self-talk." They have the ability and motivation to ask themselves a series of **HINGE QUESTIONS**.

"Can I break my negative self-talk habits?"

"Can I notice, interrupt the chain of negative self-talk?"

"Am I blowing things out of proportion?"

"Am I using self-talk that is extreme or exaggerated with words like always, never, every time, should, must?"

"Does this always happen?"

"Do I never get a chance to do what I want?"

"Am I thinking in all-or-none terms?"

"Do I think mainly about bad things that happened and not about the good things?"

"What is the evidence for or against my beliefs?"

"Can I put things in perspective?"

"Can I control my what-if thinking patterns and limit rumination?"

"What is the worst thing that can happen if it comes true?"

"And if it does occur what would be so terrible?"

"Then what would happen?"

“What would that mean?”

“How likely is that to happen?”

“Can I handle the situation if that happens?”

“Can I change to a more balanced self-talk, instead of magnifying the negatives and minimizing the positives?”

“Can I restate my negative self-talk so it is in a form that helps me achieve my goals of ...?”

13. Listen to the stories you tell others and that you tell yourself. Do your stories include:

- a) **Ways of your facing, deliberately retrieving, voluntarily processing and sharing your emotionally-charged trauma-related memories in an organized, controlled and coherent fashion;**
- b) **Consciously incorporating helpful and “wise” metaphors of survival and growth, as compared to negatively-loaded “victim” metaphors;**
- c) **Redemptive (positive endings) sequences that include what you did to survive;**
- d) **RE-words and change talk action verbs;**
- e) **Goal statements and “how to” pathways thinking;**
- f) **Problem-solving strategies, Action Plans with “if...then” statements and expressions of self-confidence and “GRIT” (dogged persistence);**
- g) **Expressions of optimism, including statements of benefit finding and benefit remembering (“Silver lining” thinking), downward comparisons (“Could have been worse”) statements;**
- h) **Meaning-making statements (“Making a gift”, “Sharing lessons learned” statements);**
- i) **Adoption of RESILIENT and GROWTH MINDSET, where change is possible.**

Ask yourself and others, if the stories you tell are elaborate, organized, coherent (having a beginning, middle and end) that are now integrated as part of your autobiographical memory? Does your story open up new possibilities for change and provide a positive blueprint for the future? If not, how can you begin to change your story? What can you do to develop a **RESILIENT MINDSET**?

SPIRITUALLY-INTEGRATED PSYCHOTHERAPY : A SELF-EXAMINATION THERAPIST CHECKLIST

What new spiritually oriented activities are you likely to try in your clinical practice?

Do you incorporate the following activities into your psychotherapeutic practice? If so, how do you use them? When there is more than one activity listed, underline which one you engage in.

YES NO

- | | | |
|---|---|---|
| Y | N | 1. <u>Communicate explicitly</u> and in your informed consent forms that it is appropriate for your clients, if they desire, to raise and discuss spiritual and religious concerns and struggles during therapy. (See Religious-Spiritual Client Intake Assessment Questions in Richards & Bergin, 2002, p. 193). |
| Y | N | 2. <u>Systematically assess</u> for my client's religious beliefs, and current <u>spiritual activities</u> . (e.g., use clinical interviews, Self-report scales) |
| Y | N | 3. Conduct an assessment of <u>spiritual developmental history</u> of my client. |
| Y | N | 4. Query my clients about how they <u>coped/survived victimizing traumatic experiences</u> and specifically <u>probe</u> about the <u>role of spiritual coping efforts</u> . For example query if the client used prayer to cope and discuss the type of prayer that was used (petition- - asking for help; intercession--asking for assistance as a go-between; confessional seeking forgiveness; lamentation- - cries of distress; adoration; thanksgiving). Did the coping effort and prayer take the form of deferring to God to intercede ; collaborative with responsibility jointly shared with God, or self-directing with responsibility in the hands of the client. |
| Y | N | 5. <u>Assess</u> for the client's, families' or communities' <u>resilience</u> and <u>strengths</u> and examples of posttraumatic growth. |
| Y | N | 6. <u>Adjust treatment interventions</u> to the cultural/ethnic religious/spiritual background of my clients (e.g., use religious metaphors). |
| Y | N | 7. <u>Use informants</u> from the client's ethnic/culture religious/spiritual background groups in order to be better informed about how to incorporate spiritual practices (e.g., Sweat Lodge activities). |
| Y | N | 8. <u>Involve religious/spiritual healers</u> as consultants and as co-therapists. Provide clergy with <u>psychoeducation</u> about evidence-based treatments and involve them in the treatment program (e.g., discuss the nature of obsessive-compulsive disorders and the rationale for exposure and response prevention procedures and exposure-based interventions.) |

- Y N 9. Refer clients to spiritually-oriented self-help groups like Alcoholics Anonymous.
- Y N 10. Engage clients in spiritual discussions and educate the clients about the pros and cons of positive and negative religious coping styles and strategies. Discuss spiritual concepts such as forgiveness, compassion, peace, love and faith.
- Y N 11. Engage in devotional activities with my clients in therapy sessions (e.g., pray together, or the therapist prays on behalf of clients that they will have the strength to deal with their personal problems and their strong, painful feelings and have the strength to change). The therapist may invite the client to pray at the beginning of the session to petition God's guidance and help during the session.
- Y N 12. Make reference to scriptures and biblical stories. For example, draw parallels between the client's redemptive role in his/ her family and the redemptive role of Jesus Christ. Help clients compare religious values such as "being a good Christian" versus the lack of forgiveness and other current behaviors.
- Y N 13. Use religious relaxation, guided imagery and spiritual meditation. For example, mentally image and rehearse a religious person like Christ being with the client in a stressful situation such as during graded exposure activities.
- Y N 14. Explore the spiritual content of dreams.
- Y N 15. Use manualized spiritually-based interventions and incorporate spiritual modules into evidence-based interventions.
- Y N 16. Participate with my clients in religious-based activities outside of therapy (e.g., attend faith-based activities such as religious services, visit funeral home, prayer vigils and rites of passage).
- Y N 17. Discuss the spiritual meaning of traumatic experiences and the nature of After-Life (e.g. in the case of clients experiencing Complicated Grief due to the violent death of a loved one and the possibility of a reunion).
- Y N 18. Incorporate mindfulness/acceptance strategies in treatment.
- Y N 19. Incorporate forgiveness activities in treatment and explore ways to forgive others, including God, as well as oneself. Where indicated, address the issue if the client feels that he /she has been abandoned or punished by God.
- Y N 20. Encourage clients to engage in spiritual activities between psychotherapy sessions such as pray and mediate, engage in spiritual relaxation and

imagery techniques, read religious bibliotherapy and scriptures, attend religious meetings, consult religious leaders, go to confession, keep a journal of their spiritual struggles, experiences and insights. Give the client religious and spiritual literature to read.

- Y N 21. Discuss values with clients and ask them to write out an “epitaph” as it presently might be written and how they would like it to read.
- Y N 22. Self-disclose to clients about your own spiritual experiences and beliefs, (e.g., model forgiveness , grace and affirmation one's faith).
- Y N 23. Intentionally avoid discussing or examining my client's religious and spiritual background and current spiritual coping efforts.

When and how do you incorporate spiritually-based interventions?

What are the dangers involved in incorporating spiritually-based interventions?

What are the alternative ways to incorporate spiritually-based interventions and how effective are they?

V. CAVAETS CONCERNING RELIGIOUS and SPIRITUALLY- BASED INTERVENTIONS

“Spirituality can play a critical role in the way traumas are understood, how they are managed, and how they are managed, and how they are ultimately resolved. Spirituality can be potentially helpful or harmful.” (Pargament et al. 2006, p. 121)

Under some conditions an individual's or group's religious beliefs and activities, as well as the form of faith-based interventions, may interfere with coping efforts and help-seeking activities, exacerbate distress and conflicts, and undermine the recovery process. The following includes some examples of how the use of spirituality might "backfire".

1. The role of spirituality varies across cultural groups. In some religious communities, mood disorders like depression, anxiety and anger and deviant behaviors may be viewed as the individual having an "absence of faith", or not engaging in prescribed rituals. Such aberrant behaviors may be attributed to "the devil's work" or to the absence of religious commitment and individuals are encouraged to pray more, attend services, and the like. It is critical that individuals with diagnosable conditions receive evidence-based treatments and that faith-based treatments do not delay appropriate treatments.
2. Under some conditions, religious beliefs can reinforce prejudicial stereotypes, contribute to intolerance (e.g., shunning, exclusion because of gender, sexual orientation, identification with a specific religious sect) and even contribute to violence. Consider the Fundamentalist view that AIDS is “God’s punishment” for homosexual behavior as an example of religious intolerance or the use of religious scripture as a source for justification of the victimization of women and the tolerance of domestic violence (see New York Times Jan. 6. 2008). Consider that the Amish were able to evidence forgiveness toward a murderer of their children, and to his grieving wife, but they did not forgive their own children who rejected their faith, as they continued to shun them.
3. Religious groups may engage in negative interactions in the form of gossiping, disagreements, cliquishness, and hypocrisy;
4. Faith may nurture "spiritual struggles" that contribute to even higher levels of distress. Individuals who tend to view God as being "punitive, withholding or abandoning them", may come to question their faith and feel punished. Individuals may get "stuck" in such spiritual struggles and experience less resolution and be viewed by significant others as having lost their faith. Consider the reactions of an incest victim:

“How could God in all his greatness have abandoned me, a little girl to the merciless hands of my father? How could he let this happen to me? I have been faithful, and for what, to be raped and abused by my own father? I hate and despise God. Your name is like salt on my tongue. I vomit it from my being. I wish death upon you. You are no more. You are dead.”

5. Spiritual beliefs can interfere with treatment. For example, several hundred children in the U.S. have died from medical illnesses because their religious parents have refused medical care primarily because the parents do not want to interfere with God's divine plan. Some religious perspectives view substance abuse as a "moral failure", requiring stronger will power or determination. Individuals may be stigmatized for seeking outside help. Substance abuse is viewed as purely a spiritual problem - - a result of demonic activity or as a hex or curse. Clients may see themselves as spiritually weak or damaged, adding to guilt, shame, humiliation and hopelessness, and that their problems are unsolvable. Only deeper faith or spiritual commitment is the remedy.
6. Clients with religious delusions evidence more conviction in their delusions and are more certain that their auditory hallucinations stem from external causes (Rosmarin & Robb, 2010). The following questions suggested by Weisman et al. (2010) may help tap such religious delusional thinking processes:

“Do you believe that God has assigned you a special role or purpose?”

“Do you consider yourself one of God’s messengers or angels?”

“Have you heard the voice of God or that of the dead?”

If the client responds “Yes” to any of these questions, follow-up probes are conducted.

7. Commitment to religious beliefs that one is a “sinner” or obsessional fear of thinking or behaving immorally or against one’s religious beliefs (“scrupulosity” as discussed by Huppert and Siev, 2010) can interfere with daily functioning and the healing process.
8. Some forms of spiritual coping have been found to interfere with adaptation and recovery. Pargament et al. (2006) reported that such coping efforts as using prayer as a form of pleading, as a means of awaiting God's interceding, or as a form of avoidant behavior contributing to delay-seeking behaviors, can lead to poorer outcomes. The attribution of stressful events to some form of demonization ("the devil") has also been found to be associated with higher levels of distress (Dyson et al. 1997; Koenig et al., 2001; Miller & Martin, 1988).
9. As to be discussed below, a collaborative self-directive prayerful stance has been found to be more adaptive. Thus, with these warnings in mind, we can explore how psychotherapists and other helpers can implement helpful spiritual activities. In fact, there is a sizeable literature emerging on the use of faith-based interventions. (See Aten et al., 2011; Eck, 2002; Frame, 2003; Fukayama & Servig, 1999; Helmeke & Bischof, 2002; Miller, 2003; Miller & Thoresen, 2003; Pargament, 2007; Richards & Bergin, 1997, 2000; Sperry & Shafranske, 2005; Wilber, 2006). Such interest is warranted, given the widespread use of religious rituals, especially in the aftermath of traumatic events.

VI. ASSESSMENT OF SPIRITUALITY

How can therapists and other helpers determine the role spirituality plays in an individual's, family's and community's coping repertoire?

Psychotherapists have used a variety of assessment approaches to tap their client's spiritual and religious orientation and behaviors. These are discussed in some detail by Hathaway et al. (2004), Hodge (2001), Hill and Pargament (2003), Koenig et al. (2001), Lovinger (1996), Moss & Dobson, 2007, Pargament (2007) and Tisdale (2003). When conducting an assessment of the client's spirituality, it is important for psychotherapists to keep in mind Watts' (2007, p. 507) observation

“Severe stress can push people to extremes in their view of religion as a way of coping. Some people who are not normally religious turn to religion under severe stress to cope. Other people, under severe stress may abandon or turn against religious beliefs and forsake their spirituality. This is especially possible if their religious beliefs were never strong to begin with.”

Whenever conducting spiritual assessments, psychotherapists need to be respectful and non-judgmental and supportive of their client's current beliefs and behaviors.

The approaches to assess spirituality may include:

- 1) **Clinical Interviews;**
- 2) **Self-report Scales;**
- 3) **Assessment of developmental and current influences and social supports in the form of a Spiritual Genogram, or having the client write a Spiritual Autobiography using a timeline;**
- 4) **Current self-monitoring and journal writing of personal striving, religious activities and behaviors.**

CLINICAL INTERVIEW

In their initial intake psychotherapists can ask explicitly about spirituality in the form of a series of open-ended questions and can then supplement the interview with various Self-report Scales to probe further about the role spiritual activities play. Questions may be raised about the client's traditional and nontraditional religious and spiritual background, past and current religious practices (e.g., use of prayer, scripture reading, spiritual coping, contemplation, meditation), presence of any spiritual conflicts, issues and current spiritual needs, and spiritual and religious resources available. The following questions illustrate some of the ways such spiritual assessment may be conducted.

Pargament (2007) suggests that psychotherapists can conduct an initial spiritual assessment of their clients by asking questions such as:

Do you see yourself as a religious or spiritual person? If so, in what way?

Are you affiliated with a religious or spiritual denomination or community? If so, which one?

How important is religion (or your faith) in your life?

How often do you attend religious services and engage in religious activities (prayer, Bible reading, use of scriptures, etc)?

How do you (and your family) go about coping with stress?

Has your problem (or experience - be specific) affected you religiously or spiritually? If so, in what way?

Has your religion or spirituality been involved in the way you have coped with your problem (situation)? If so, in what way?

It seems that there is a spiritual dimension to your problem?

Do you believe that religious or spiritual influences have hurt you or contributed in some way to your problems?

Do you think there is a religiously-based reason for your suffering? (Presence of a "spiritual struggle")

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? If yes, what are they?

Do you believe you can experience spiritual guidance?

Would you like your therapist/counselor to consult with your religious leader if it appears this could be helpful to you?

Are you will to consider trying religious or spirituals suggestions from your therapist/counselor if it appears that it could be helpful to you?

It sounds like your faith (religion, spirituality) may be a potential resource in dealing with your problem (situation)?

How would you feel about exploring the spiritual side of your situation?

When trauma is the focus of attention, the following questions may be asked.

Let me ask what happened. (The therapist should probe about the traumatic experience, allowing the client to tell his/her story at own pace. The

psychotherapist should listen for any instances of how the client used prayer or other forms of spirituality as a means of surviving or coping. The therapist can then ask the client about how such praying helped and explore the general role of spirituality in the client's life.)

Have you been able to make sense of, or find any meaning in what happened to you? (Be specific in noting the loss or trauma-death of X, destruction of your home, relationship with Y)?

Has your religion or faith helped you to cope with or handle the emotional aftermath of what you have been through?

Do you see any possible ways that your faith (religious beliefs) could be of help?

Have you ever wondered, "why me?", "Why now?"

Have you struggled to make sense of ...? What answers, if any, have you come to?

Was it as bad as it could have been?

Has anything good come out of this event?

Do you see God's grace in the midst of this tragedy?

To what extent are you able to put this behind you?

What advice, if any, would you have for someone who finds him/herself in a similar situation?

Griffith and Griffith (2002) and Pargament (2007) discuss how to talk with people about their spiritual lives and they suggest using "psycho-spiritual language", exploring the client's views about courage, peace, purpose in life, that frequently leads into a consideration of the client's notions about faith and spirituality. For instance, consider the following questions:

When you are afraid or in pain, how do you find comfort and solace?

What sustains you in the midst of your troubles?

From what sources do you draw the strength and courage to go on?

What are the deepest questions your situation has raised for you?

How has this situation shaken your faith?

When in your life have you experienced forgiveness?

What legacy would you like to leave behind in your life?

SPIRITUAL ASSESSMENT QUESTIONS suggested by Bill O'Hanlon

Spiritual History/Background

“What have been your religious affiliations, if any?”

“Have those affiliations been helpful in any way?”

“What did each of your parents teach you or show you about religion or spirituality?”

“Who else, if anyone, influenced you in regard to religion or spirituality?”

“If you ever went away from religion or spirituality and then returned, how did that happen?”

“What was the period in your life when you most relied on religion, spirituality or faith for strength?”

Current Spirituality

“What role, if any, does religion/spirituality play in your life currently?”

“If you were to name the best aspect of religion, what would it be?”

“What do you think is the worst aspect of religion?”

“Describe the time or activity that makes you feel the most spiritual?”

“Who is the most spiritual person you know?”

Future Spiritual Hopes and Intentions

“What kind of spiritual or religious activities would you like to do in the future, if any?”

“Is there any spiritual or religious figure that you would like to use as a model for you? In what way?”

“What do you think happens to us when we die?”

“What would be the one thing you could add to your life that you think would make your life more spiritual?”

QUESTIONS DESIGNED TO NURTURE A POSITIVE FOCUS

COMPARE ONESELF WITH OTHERS WHO ARE NOT DOING AS WELL

“Compared to others, do you feel you are in a better or worse situation?”

IMAGINE WORSE SITUATIONS (WORSE ALTERNATIVES, WORSE POSSIBLE OUTCOMES)

“Has anything that has happened made you feel particularly lucky?” (e.g., Damage not worse; little injury to self or others)

FORGETTING THE NEGATIVE

“To what extent are you able to put this out of your mind?”

REDEFINING

“Is this experience as negative as you would have imagined before going through it?”

FINDING SIDE BEFEFITS

“Has anything positive come out of this experience for you?” (e.g., Bring families closer together; elicit support and caring from friends and neighbors; elicit helpfulness; make you more aware of the preciousness of life in a way that other daily events are not able to do; good deeds come from this; spiritual and/or material benefits; learned a lesson)

MAINTAINING A SENSE OF HOPE

“Are there any way things may be better as a result of this event occurring?”

SELF-REPORT INSTRUMENTS

Pargament (2007) reviews 26 self-report instruments designed to assess the clients' spirituality and religious behaviors. These varied measures are designed to assess the client's:

- 1) spiritual development and influences across his/her life-span and current network of social supports;
- 2) religious orientation and activities, spiritual strivings, experiences and sense of spiritual well-being;
- 3) methods of spiritual coping;
- 4) spiritual “struggles,” doubts and conflicts.

There are distinct spiritual assessment inventories for Christians, Jews and Hindus. The following is an illustration of some of the many types of self-report measures of spirituality.

Illustrative Measures Of Religious Behaviors And Spirituality

Religious Coping Index	Koenig et al., 1992
RCOPE	Pargament et al., 2000
Religious Problem-Solving Scale	Pargament et al., 1988
Spiritual Well-being Scale	Ellison, 1983
God Locus of Health Control Scale	Wallston et al., 1999
Faith Situations Questionnaire	Hathaway et al., 2003
Cultural and Family Genograms	Hardy & Laszloffy, 1995

For example, Pargament et al.'s Religious Problem-solving Scale assesses three styles:

Self-directing style - - people believe that it is their own responsibility to resolve their problems ("God is not involved directly in this process. Rather God is viewed as giving people the freedom and resources to direct their own lives.")

Deferring style - - defer the responsibility of problem-solving to God. Wait for solutions to emerge through the active efforts of God.

Collaborative Style - - responsibility for the problem-solving process is built jointly by the individual and God. Both are viewed as active contributors working together to solve problems.

Another means to assess the clients' Spiritual and Religious Activities is to use the following **CLIENT CHECKLIST**. Note that having clients fill out this Checklist and reviewing it with them, can offer multiple suggestions for intervention strategies. Assessment and treatment can be readily intertwined.

SPIRITUAL AND RELIGIOUS HEALING ACTIVITIES CHECKLIST FOR CLIENTS

This **Checklist** is designed to determine how many of the following **Spiritual Healing Activities** you have engaged in and whether you found them **HELPFUL** or if you tried them and found them **UNHELPFUL** in your personal journey of healing. If you did not engage in this particular spiritual activity, then leave the item **BLANK**.

TRIED IT		SPIRITUAL ACTIVITIES
HELPFUL	NOT HELPFUL	BELIEFS
_____	_____	1. Hold the belief that God rescued me from this trauma experience for some reason, work or mission.
_____	_____	2. Belief that my traumatic experience made my faith stronger.
_____	_____	3. Began a pilgrimage of healing - - move from being a “victim” to a “survivor” to a “thriver”.
_____	_____	4. Found in my faith the possibility of compassion, forgiveness.
_____	_____	5. View God as a “supportive partner” and confidant.
_____	_____	6. Learned to walk away from anger and hatred.
_____	_____	7. Learned to stop ruminating, asking “why” questions.
_____	_____	8. Came to terms with what happened - - use acceptance strategies.
_____	_____	9. Regained the capacity to HOPE – in myself- in life- in others- in God.
		ENGAGE IN RELIGIOUS AND SPIRITUAL ACTIVITIES
_____	_____	10. Visit with the Chaplain (minister, Rabbi, Iman)
_____	_____	11. Attend Religious Services. become part of a group that worships or practices together , such

as a congregation, a prayer circle, a scriptural study group, or meditation center. This may be a physical group that meets in person at a designated location, or an online community

- | | | |
|-------|-------|--|
| _____ | _____ | 12. Use public prayer. |
| _____ | _____ | 13. Use silent prayer (Talk to a Higher Power). Set aside a time for prayer or meditation as part of my daily routine. This is often the first thing in the morning or the last thing at night, or both. |
| _____ | _____ | 14. Engage in scripture reading. Make a regular habit of reading scriptures, sacred texts, or other writings pertaining to my chosen faith or practice. Design a physical location for my daily spiritual practice. This may be a room or smaller place in my home or a location in nature . |
| _____ | _____ | 15. Participate in religious activities as a way of getting social support. |
| _____ | _____ | 16. Listen to or participate in religious/spiritual meetings (chorus, rituals). |
| _____ | _____ | 17. Participate in spiritual issues/discussion groups. |
| _____ | _____ | 18. Meditate or use some form of Mindfulness activities. |
| _____ | _____ | 19. Use spiritually-guided imagery. |
| _____ | _____ | 20. Write out a spiritual autobiography in order to consider the origins of my religious beliefs and how these have changed. |
| _____ | _____ | 21. Keep a journal of my healing process. |
| _____ | _____ | 22. Engage in forgiveness, atonement or repentance activities. |
| _____ | _____ | 23. Engage in spiritual rituals such as Sweat Lodge activity, drumming, chanting, dancing, art expressive activities. Practice a physically active form of spirituality such as engaging in |

a walking prayer, yoga, martial arts, liturgical dancing, playing sacred music, painting, drawing with the goals of expressing sacred ideals, or writing spiritually-inspired poetry.

- | | | |
|--|--|---|
| | | 24. Revisit the grave site or Memorial Wall, or a Monument to commemorate those who have been lost. |
| | | 25. Revisit the site of the trauma experience and participate in a commemorative memorial. |
| | | 26. Visit with family members of those involved in trauma experience. |
| | | 27. Do a good deed. "Pass-forward". |
| | | 28. Make a "gift" of my experience to others. |
| | | 29. Use the Serenity Prayer
<i>"God grant me the grace to accept with serenity the things that cannot be changed, courage to change the things which should be changed, and the wisdom to distinguish one from the other"</i> . |
| | | 30. Other Spiritual Activities that I engage in _____

_____ |

A CASE CONCEPTUALIZATION MODEL (CCM)

“A clinician without a Case Conceptualization Model is like a Captain of a ship without a rudder, aimlessly floating about with little or no direction”

A well formulated Case Conceptualization Model (CCM) should:

1. identify developmental, precipitating and maintaining factors that contribute to maladaptive behaviors and adjustment difficulties and that reduce quality of life;
2. give direction to both assessment and treatment decision-making;
3. provide information about the developmental, familial, contextual risk and protective factors;
4. highlight cultural, racial and gender-specific risk and protective factors;
5. identify individual, social and cultural strengths that can be incorporated into the treatment-decision making;
6. provide a means to collaboratively establish the short-term, intermediate and long-term goals and the means by which they can be achieved;
7. identify, anticipate and address potential individual, social, and systemic barriers that may interfere with and undermine treatment effectiveness;
8. provide a means to assess the client’s progress on a regular basis;
9. consider how each of these objectives need to be altered in a developmentally, culturally, ethnically and racially sensitive fashion
10. nurture hope in both the patient and the treatment team.

REFERENCES ON CASE CONCEPTUALIZATION

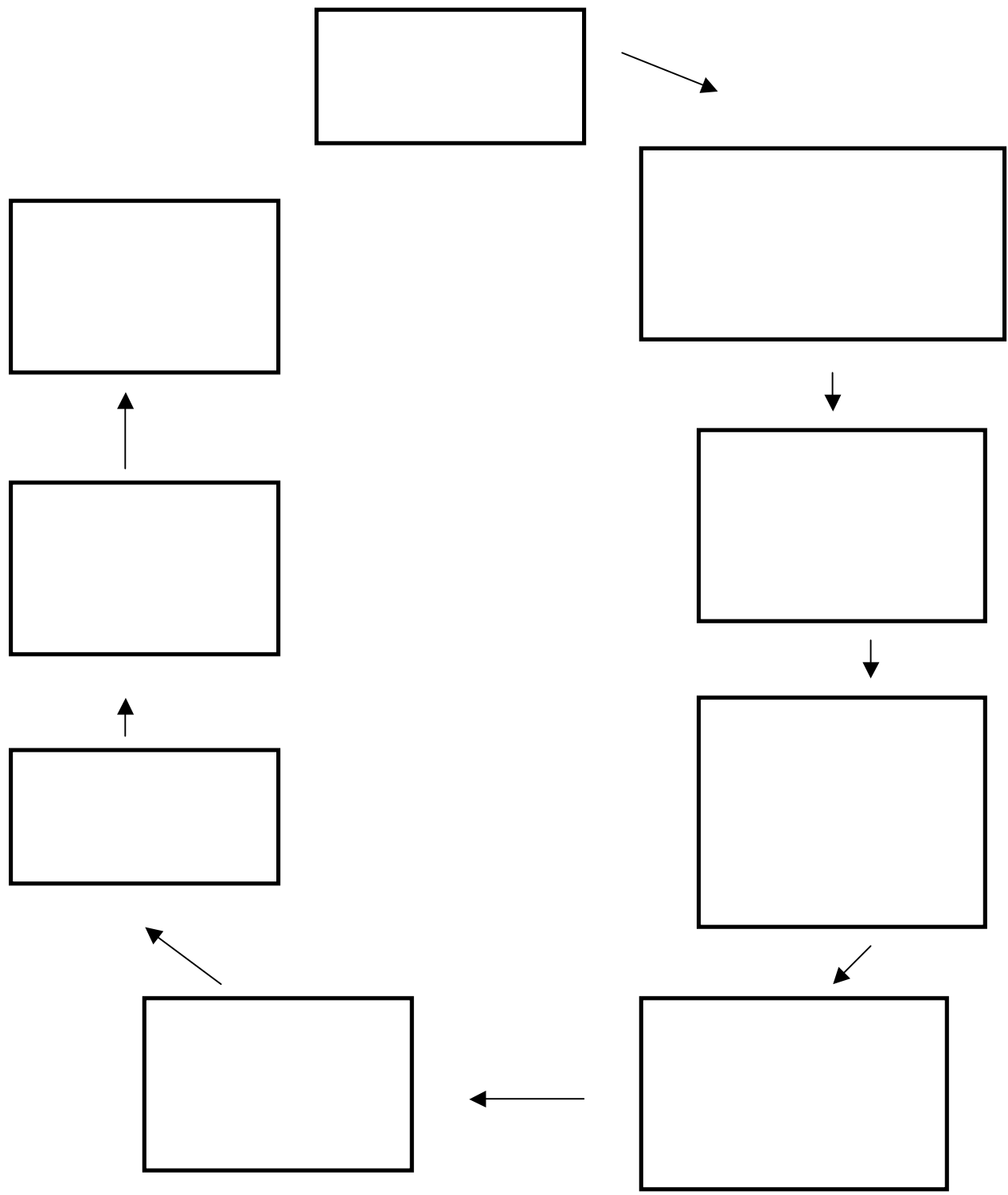
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9. Outcomes (Risk) 6. Strengths
8A: Short-term 6A: Individual Information
8B: Intermediate 6B: Social
8C: Long-term 6C: Systemic

1A. Background
1B. Reasons for Referral

5. Treatments Received
2A. (Current) Problems
(Symptoms) (Presenting Dist.)
3A. Affect (Dist.)
3B. Affect (Functioning)
3C. Affect (Social)
3D. Affect (Family)
4A. Intellectual
4B. Emotional
4C. Behavioral
4D. Family

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 is ...” (distress, symptoms, present and in the past)
“And it is particularly bad when ...” “But it tends to improve when you ...”
“And it is affecting you (how ... in terms of relationships, 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 (stressors) that you are currently experiencing that seem to maintain your problems are ... or that seem to exacerbate (make worse) are ...: (Current/ecological stressors)
“And its not only now, but this has been going on for some time as evident by ...” (Developmental stressors)
“And its 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 strengths)

BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

“Have I captured what you are 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 achieved 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 planning. 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)

VII. TYPES OF SPIRITUAL COPING ACTIVITIES

Not all forms of religious coping strategies are equally beneficial. Positive religious coping refers to strategies that reflect a constructive turning to religion for support, meaning and solace. In contrast, negative religious coping strategies are ways of engaging in religious struggles, doubts and avoidance and deferment of personal responsibility. Negative religious coping elicit feelings such as anger, guilt and shame that undermine the recovery process.

Pargament and his colleagues (1990, 1998) and Gall and colleagues (2005) have enumerated the variety of **spiritual coping activities** that individuals may engage in. These include;

- a) Engaging in spiritually-based activities (Use prayer and participate in religious workshops; participate in formal religious rituals; read and study scriptures; practice sacramental confession);
- b) Feeling strengthened (Having trust and hope in a higher power; saying grace - thank God for your survival and what one has left; believe you survived for a purpose). Recognize your Divine self-worth and examine your personal life purpose and mission. Highlight the redemptive value of suffering: *"What doesn't kill us makes us stronger", "No pain, no gain"*.
- c) Calling upon forgiveness (Use acceptance strategies; See self as having limited ability to understand the entirety of such events and thus need not continue searching for reasons and discontinue asking "why" questions for which there are no answers. Engage in "non-negative" thinking.)
- d) Performing spiritual acts (Do good deeds, help others, engage in volunteer activities; make contributions to faith communities and to helping agencies; Meditate, introspect, use spiritual-guided imagery, fasting, drumming, chanting, go on a spiritual retreat; Connect with nature and all living things – enjoy nature, gardening; Lead a "good life"). For example, Hinton et al (2006) provides an example of how to treat survival guilt in Buddhist clients by having them participate in religious activities such as "merit making" in the form of good deeds. It is believed that the earned merit promotes a good rebirth for the deceased and good luck for the merit maker.
- e) Seeking religious support (Attend religious services and ceremonies; Watch religious television, listen to religious radio programs and religious music; Believe in afterlife and reincarnation; Call upon the clergy and have a sense of belonging to a community and a sense of continuity with past groups). View traumatic events as a way of bringing individuals together.
- f) Appreciating life (Reprioritizing life and appreciate that the "simple joys of life are everywhere and boundless" and that "everything is a gift". God works in many different ways. The world is benevolent-but not always. The world is comprehensible- but not always (see Janoff-Bulman, 2006; Meichenbaum, 2006).

- g) Constructing meaning (Out of suffering seek significance in the event – a kind of God’s “wake-up” call; Make benign attributions and find remaining benefits; Generate a list of aspects of one’s life that you are grateful for; Reprioritize; Determine that the event is less central to one’s life than originally perceived; Make a “gift” of one’s suffering to others – “lessons learned” to be passed on; Reappraise original situations as not being all that “bad”)
- h) Pleading with God
- i) Engaging in avoidant coping efforts
- j) Viewing traumatic events from a punitive perspective

It is the latter three forms of religious coping activities (pleading, engaging in avoidant behaviors and adopting a punitive stance) that most readily interfere with the healing process. (See below for a description of these three forms of “negative” coping strategies).

Further Examples of Adaptive Spiritual Coping Activities

The following are examples offered by religious/spiritual people in coping with traumatic and stressful events. These spiritual coping activities will vary across religious groups and also vary in their adaptive benefits (see Gall et al, 2005; Pargament 2007; Pargament et al, 1990; and Worthington, 1998)

Faith-based beliefs to cope

- *I believe in a just and benevolent God. I look to God for emotional strength. I trust that God would not let anything terrible happen to me. I trusted the Lord to help me.*
- *I never doubted that God would have the ability to see me through and give me a way out.*
- *I realized that I didn’t have to suffer since Jesus suffered for me.*
- *I use Christ as an example of how I should live. I took control over what I could do and gave the rest up to God.*
- *My faith showed me different ways to handle the problem.*
- *My relationship with God is what I’m most thankful for. With him all things are possible.*
- *Whatever I lost I’ve gained back triple through my spiritual walk with Jesus. I am so grateful to greet each day.*
- *I accept that the situation was not in my hands, but in the hands of God.*

- *I experience God's love and care.*
- *God is greater than evil and God can use this for His good purposes.*
- *I let the Holy Spirit use me or use others as an instrument to accomplish God's work of healing and forgiveness.*
- *We are not perfect and God loves us. God would never discard us.*
- *This is part of God's plan. I am along for the ride.*
- *What sustains me is my belief in an afterlife.*
- *I am open to and trust in the eventual discovery of meaning and solutions to life's problems.*
- *I am guided by my religious beliefs.*

Engage in Purification and Religious Activities

- *I engage in ritual sacrifice, cleansing ceremonies.*
- *I participate in atonement activities.*
- *I go to spiritual confession.*
- *I engage in religious activities (e.g., pray before meals, light Sabbath candles, daily affirmations, renew our wedding vows, participate in transitional faith-based activities birth, marriage, coming of age, grief bereavement activities and rituals).*
- *I seek a new, higher purpose in life.*
- *I do what I can and I leave the rest in God's hands.*
- *I work together with God as partners in problem-solving.*

Feel Strengthened as a Result of Having Endured and Survived

- *This is God's way of testing me (us). Testing our faith. This is a spiritual "wake-up call" from God. God speaks to us through pain. God has his reasons.*
- *This is God's way to see if you are going to stay true to what you believe and stay faithful.*
- *I use my strengths in a new way.*

- *I feel purified by this crisis.*
- *This is God's way of teaching us about the preciousness of life.*
- *I look to God for strength, support and guidance.*
- *I bear witness, publish memoirs, engage in commemorative ceremonies, take political actions.*

Call Upon Forgiveness

- *Jesus had died so that I might have forgiveness.*
- *If God forgives us and can cast away our sins totally, why couldn't I just forgive?*
- *I have more compassion for others and for myself.*

Perform Good Deeds

- *I try to be less sinful.*
- *I lead a more loving life. I try to live morally and ethically.*
- *I provide help to others. I engage in acts of kindness and compassion toward others.*
- *I show my gratitude to others in my life.*
- *I help inspire and teach others. I reach out and pass on the lessons I learned. I try to make the world a better place.*
- *I engage in an educational mission. I make a "gift" of my experiences and what I did to survive.*

Call upon Religious Supports

- *I seek support from clergy and/or from other members of the congregation. I participate in healing groups and devotional activities.*
- *I play my religious music and it lifts my spirits.*
- *I sing in the church choir.*
- *I watch religious television*
- *I study the Bible and other sacred texts.*

- *I meditate regularly.*

The following three coping activities have been found to have detrimental maladaptive impact.

Plead

- *I pray for a miracle. Request divine intervention.*
- *I bargain with God to make things better.*
- *I continually ask God "Why it happened?"*

Engage in Avoidant Coping Efforts

- *I try not to think about it.*
- *I keep my feelings to myself.*
- *I avoid being with other people.*
- *I prayed (or wish) for a solution and pray that the problem would just go away.*
- *I focus on the world to come, rather than on the problems of this world.*
- *I let God solve my problems for me.*

View Events from a Punitive Perspective

- *This is a punishment from God for our sins.*
- *God is all powerful and controlling and at times punitive.*
- *I feel God has abandoned me. I pray for God's love.*
- *I think the devil is behind this.*
- *I have doubts about my faith because God let me down.*
- *The Son and the Holy spirit I can accept, but I will never accept God. He could have prevented all of this. I see no reason.*
- *I am too angry with God to accept my faith anymore. I blame God who could have prevented all of this.*

VII. CORE TASKS OF PSYCHOTHERAPY: WHAT “EXPERT” THERAPISTS DO BASED UPON THERAPEUTIC PRINCIPLES OF CHANGE

(See Castonguay & Beutler, 2006; Goldfried, 1980, 2007; Goldfried & Burum, 2007; Grencavage & Norcross, 1990; Meichenbaum, 1997, 2001; Nathan & Gorman, 2002; Safran & Muran, 2000)

1. Develop a collaborative **therapeutic relationship/alliance** and help the patient "tell" his/her story. After listening attentively and compassionately to the patient's distress and "emotional pain", help the patient identify "strengths" and signs of resilience. *"What did he/she accomplish in spite of ...?" "How was this achieved?"* Obtain the "rest of the story". Use Socratic Questioning.
 - i. Foster bonding between the patient and therapist. Address any ruptures or strains in the therapeutic alliance and address any therapy-interfering behaviors.
 - ii. Collaborate with the patient in establishing treatment goals and the means to achieve these goals.
 - iii. Encourage the patient's motivation to change and promote the patient's belief that therapy can help. (Use Motivational Interviewing procedures.)
 - iv. Monitor the patient's progress and use the information to guide ongoing treatment.

2. Be **culturally-sensitive** when conducting assessments and treatment and **develop knowledge** and **competence** in ethnic diversity.
 - i. As Bowman (2007) highlights, *"Become more aware of your existing assumptions, and accept that some of these assumptions may not apply to ethnic minority groups" (p. 113)*
 - ii. Conduct an ethnocultural assessment that taps the patient's level of acculturation, circumstances and impact of migration on family and on self.
 - iii. Assess for culturally specific symptomatology and provide culturally-based interventions.
 - iv. Treatment should be sensitive to the patient's expectations, cultural interpersonal style, values and metaphors/language. Interian and Diaz-Martinez (2007) provide a good example of such cultural adaptation with Hispanic patients as they alter psychotherapy to include such Hispanic concepts such as Simpatico, Respeto, Fatalismo (setting examples), examples of other culturally and spiritually-oriented interventions). In conducting these culturally-based interventions, it is important not to impose cultural stereotypes and recognize marked differences within cultural groups (*See Meichenbaum, 2009, www.melissainstitute.org on Ethnicity, race and mental health*).

- v. Tailor interventions to ethnic groups. For example, see Hinton et al., (2006) treatment of Cambodian refugees for treatment of panic attacks. Use a **“Clock Metaphor”**
 - vi. Address any potential cultural barriers that might arise in treatment.
 - vii. Be willing to consult with individuals who may be more equipped to deal with ethnic diversity and learn to conduct multicultural therapy.
3. On an ongoing basis **educate** the patient about his/her problems and possible solutions and **facilitate awareness**. Use various ways to educate and nurture a sense of curiosity and discovery.
- i. Conduct Risk and Protective Factors assessment and provide constructive feedback. Probe about the patient’s views of presenting problems and his/her theories of behavioral change.
 - ii. Use a Case Conceptualization Model and share therapy rationale.
 - iii. Have the patient engage in self-monitoring and conduct situational and developmental analyses.
 - iv. Use videotape modeling films and other educational materials (simple handouts with Acronyms).
 - v. Use a “Clock metaphor” – “Vicious Cycle” Model

12 o'clock - external and internal triggers

3 o'clock - primary and secondary emotions

6 o'clock - automatic thoughts, thinking patterns and schemas or beliefs. Note common core recurrent patterns

9 o'clock - behaviors and resultant consequences

The therapist can use his/her hand to convey the **Clock Metaphor** by moving his/her hand slowly from 9 o'clock around to 6 o'clock. The therapist can say:

“It sounds like this is just a vicious...(without completing the sentence) allowing the patient to interject- - "cycle or circle". To which the therapist can then say, “In what way is this a vicious cycle? Are you suggesting...?”

The therapist can then help the patient come to appreciate how his/her appraisal of situations (12 o'clock), feelings (3 o'clock), thoughts (6 o'clock) and behaviors (9 o'clock) are all interconnected. The patient can be invited to “collect data” (self-monitor), if indeed, the “vicious cycle”, as the patient describes it, actually occurs. In this way, the patient can bring into subsequent sessions data supporting the Clock Metaphor.

“If you (the patient) are engaging in such cyclical behaviors, then what is ‘the impact, what is the toll, what is the emotional and behavioral price’ that you and others are paying? Is that the way you want things to be? If not, then what can you do about it?”

It is not a big step for the patient to suggest that one of the things he/she could do is “Break the cycle”. “Break the cycle. What did you have in mind?”, the therapist can ask. The therapist can now explore collaboratively with the patient how he/she can break the cycle. Moreover, the therapist can help the patient come to appreciate how he/she has already been trying to “break the cycle” (e.g., by engaging in avoidance behaviors, dissociating, isolation, self-medicating, using substances or being aggressive).

Another way to use the **Clock Metaphor** is to help the patient view his/her primary and secondary emotions (3 o’clock) as “commodities” that the patient does something with. The therapist can ask:

“What do you do with all those feelings (emotions)?”

The patient may respond that he/she “stuffs the feelings”, or “drinks them away”, and if he/she does that, then what is the impact, the toll, the price he/she pays. Is that the way he or she wants things to be? If not, then what can be done about it?”

Once again, the therapist can use the “art of Socratic questioning” as a way to help the patients generate possible coping solutions. There is a greater likelihood of patients engaging in behavior change efforts if they come up with the ideas and the accompanying reasons for engaging in such behaviors, than if the therapist merely offers suggestions and directives, acting as a “surrogate frontal lobe” for his/her patients.

- vi. Therapist models thinking: Ask the patient: ***“Do you ever find yourself, out there, in your day-to-day experience, asking yourself the kind of questions that we ask each other right here?”***
 - vii. Educate the patient about relapse prevention strategies.
 - viii. There is a **caveat** that should be highlighted concerning the psychoeducation of patients. For instance, it is possible to exacerbate patient distress by providing information about future symptoms and challenges before some form of hope and coping responses have been developed (see Devilly et al. 2006 for a discussion of such dangers).
4. Help the patient **reconceptualize** his/her "problems" in a more **hopeful** fashion.
- i. Do a life-review (***Use Time-lines***). Identify "strengths."
 - ii. Use collaborative goal-setting (short-term, intermediate, long-term goals)
 - iii. Use videotape coping modeling films (*see www.warfighterdiaries.com*)

- iv. Use letter-writing, journaling
 - v. Use group processes – open-ended groups
 - vi. Alumni clubs
 - vii. Use hope-engendering mentors
5. Ensure that the patient has intra- and interpersonal **coping skills**
- i. Highlight the discrepancy between valued goals and current behavior and consequences and consider what can be done to close this gap.
 - ii. Train and nurture specific skills to the point of mastery.
 - iii. Build in generalization – do not merely “train and hope” for transfer (Follow the specific steps of what you need to do to achieve generalization and ensure maintenance. *(See Meichenbaum, 2007, pp. 334-340.)*)
6. Encourage the patient to **perform "personal experiments"**
- i. Solicit commitment statements and self-explanations – reasons for behavioral change.
 - ii. Facilitate “corrective emotional experiences” (ala Alexander & French, 1946).
 - iii. Involve significant others.
 - iv. Ensure that the patient takes the "data" from his/her personal experiments as "evidence" to unfreeze his/her beliefs about self, the future and the world.
7. Ensure that the patient **takes credit** for change
- i. Use attribution training -- use metacognitive statements ("notice," "catch," "interrupt," "game plan")
 - ii. Nurture a sense of mastery and efficacy (*“In spite of ... How were you able to ...?”*) Use the language of “becoming” and of possibilities.
 - iii. Monitor the degree to which the patient ascribes personal agency for change. Note the number of unprompted examples of where the patient takes the therapist’s voice with him/her.
 - iv. Help the patient change his/her personal narrative or the “stories” he/she tells oneself and others.
8. Conduct **relapse prevention** – follow treatment guidelines on how to conduct relapse prevention (*See Meichenbaum, 2007, pp. 347-359*)
- i. Be sensitive to the patient’s beliefs, behaviors and interpersonal conflicts that may block recovery.
 - ii. Consider the episodic nature of the patient’s disorder and any possible anniversary effects.
 - iii. Identify high-risk situations and develop coping strategies.
 - iv. Consider family and peers factors that can both undermine and support change. Consider the impact of a High Expressed Emotional Environment on the process of the patient (criticism, intrusiveness).

ADDITIONAL PSYCHOTHERAPEUTIC TASKS FOR TREATING PSYCHIATRIC PATIENTS WITH A HISTORY OF VICTIMIZATION

(Note that approximately 50% of psychiatric patients have a history of victimization.)

9. Address **basic needs** and **safety** and help the patient develop the tools for **symptom regulation** including treating symptoms of **comorbidity**
 - i. Treat the patient for the sequelae of PTSD and Complex PTSD
 - ii. Conduct an **integrated treatment** program, rather than sequential or parallel treatment programs
 - iii. Normalize, validate and reframe symptoms as a means of coping and as a form of survival processes. Characterize the patient's symptoms as a reflection of a "stuckness" issue, whereby the patient is "stuck" overusing a coping response that once worked which is no longer required (e.g., a veteran continuing to be hypervigilant when it is no longer required).

10. Address "**memory work**" and help with the patient's belief system
 - i. Consider various forms of "retelling" trauma story -- A "restorying" process
 - ii. Relive with cognitive restructuring: Contextualize memories --discriminate "then" and "now", putting memories in the past
 - iii. Consider what implications (beliefs) the patient has drawn as a result of victimization experiences ("*What lingers from ...*"; "*What conclusions do you draw about yourself and others as a result of ...*")
 - iv. Consider impact of "shattered assumptions" and how to rescript narrative. Listen for and use the patient's use of metaphors

11. Help the patient **find "meaning"**: Adopt a constructive narrative perspective
 - i. Consider what the patient did to "survive"
 - ii. What evidence of strengths in self and in others
 - iii. What "lessons" learned that the patient can share with others – What can be salvaged from survivorship that the patient can make a "gift" to offer others

12. Help the patient **re-engage** and "**reconnect" with others**: Address the impact of trauma on family members, significant others and community.
 - i. How move beyond "victim" role to that of being a "survivor", even a "thriller"
 - ii. How engage in a proactive "helper" role
 - iii. How to connect with **adaptive/supportive** peers and community resources

13. A major way individuals often cope with the aftermath of exposure to traumatic events is to use some form of religion or spirituality. There is a need for therapists to explore with

patients for whom such spiritually-oriented coping procedures are central, various ways to integrate them into the psychotherapy process. In doing so, therapists need to be sensitive to cultural, developmental and gender differences.

- i. Assess for the role of spirituality in coping process
 - ii. Where indicated, collaborate with local healers
 - iii. Work with local social organizations and social support systems
14. Help the helpers. “Expert” psychotherapists monitor, assess and attend to the impact of vicarious traumatization.
- i. Interventions at the individual level
 - ii. Interventions at the social or collegial level
 - iii. Interventions at the level of the social agency
 - iv. Work with local social outreach agencies
 - v. *See www.melissainstitute.org for a Handout on Resilience*
 - vi. *See www.melissainstitute.org Handout on Ways to Reduce Vicarious Traumatization and Increase Vicarious Resilience in Helpers*

VIII. INTEGRATION OF SPIRITUALITY AND PSYCHOTHERAPY

How can therapists (helpers) incorporate spiritual faith-based activities into their treatment?

A number of authors have offered specific suggestions on how to integrate spiritually-oriented psychotherapeutic interventions. See Griffith and Griffith (2002), Miller (1999), Miller and Martin (1998), Pargament et al (1992), Plante and Sherman (2001), Propst (1987) and Richards and Bergin (1997, 2000). Tan (1994) has described two forms of spiritually-oriented psychotherapeutic interventions, namely, **Implicit** and **Explicit**. In the **Implicit Form**, the psychotherapist rarely initiates communication or interventions about spirituality, or if they do so, it is more indirect following the lead of the client. In the **Explicit Form**, the psychotherapist directly initiates spiritually-oriented interventions. Pargament (2007) has described several **Spiritually-oriented Manualized Treatment Programs** that provide between 4 to 10 sessions of individual and group spiritually-oriented interventions for individuals with such diverse clinical problems as HIV/AIDS, eating and addictive disorders, social anxiety and depression, medical illnesses, as well as victims of sexual abuse and divorced couples. These **Explicit Treatment Programs** employ several spiritually-oriented interventions including prayer, meditation, spiritual visualization, reframing, support, journaling, scripture reading, purification rituals, forgiveness activities and encouraging spiritual virtues such as sharing, empathy, gratitude, and appreciation.

A number of Spiritually Integrated Treatment (SIT) programs have been evaluated. Smith et al. (2007) conducted a meta-analysis and reported an overall Effect Size (ES= .51) among 24 comparisons of SIT versus established other treatments. These spiritually-oriented manualized psychotherapeutic interventions go under such names as Lighting the Way (Pargament et al., 2004); Recreating Your Life (Cole and Pargament, 1988); Spiritual Renewal (Richards et al., 2000); Sacred Moments (McCorkle et al., 2005); Coping with Divorce (Rye & Pargament, 2005); Becoming a More Forgiving Christian (Worthington, 2005); From Vice to Virtue (Ano, 2005); Solace for the Soul (Murray-Swank & Pargament, 2005); Jewish Adolescent Values Program (Dubow et al., 2000); and Spiritual Self-Schema Therapy (Avants et al., 2005); and Spiritual Beliefs and Values Groups for psychiatric patients (Kehoe, 1998). Some treatment programs help clients address their feelings of anger, abandonment and isolation by using a "Cry Out to God" intervention based on the Psalms of Lament and by imaging themselves as characters in different Biblical stories. Faith-based initiatives in the form of a Kairos Horizon program have been used in 250 prisons in 30 states in the U.S. The spiritually-oriented training modules in the Kairos program involve worship and prayer time, making peace with the past and substance abuse programs. Indeed, the most widespread example of a spiritually-oriented intervention is Alcoholics Anonymous 12 Step Program that reminds participants to employ the **Serenity Prayer**:

“God, give me the grace to accept with serenity the things that cannot be changed, courage to change the things which should be changed, and the wisdom to distinguish one from the other.”

Each of these spiritually-oriented interventions need to be conducted in a sensitive respectful, collaborative fashion, soliciting the client's feedback throughout. The therapist needs to follow the lead of the client by asking reflective questioning. It is critical that the therapist does not impose his/her spiritual views on the client. Even if the psychotherapist is an agnostic or an atheist, the task is to help the client use the spiritual and other coping tools that he/she brings to the psychotherapy.

The following is a list of spiritually-oriented interventions that psychotherapists have incorporated into their treatment. In each instance, there is a need to implement them only with the permission of the client and with his/her collaboration. As noted, the psychotherapist needs to actively solicit the client's feedback on each intervention and relate these spiritually-based activities to the client's treatment goals. The psychotherapist and the client need to consider together **how engaging in each of these spiritually-oriented activities will help the client achieve his/her treatment goals.**

The psychotherapist and the client can address the following questions and relate the psychotherapeutic and spiritually-based interventions to the various treatment goals. The formulation of achievable goals nurtures "hope." The psychotherapist can ask:

"How are things today and how would you like them to be and achieve your goals? What can we (the therapist and the client) do to get them that way? What have you tried in the past? What has worked and what hasn't worked? What obstacles or barriers have gotten in the way? How will using these spiritual activities help you achieve these goals? How could we tell if the you (the client) are making progress? What would change? What changes would people notice? What barriers or obstacles might get in the way of these changes? What can be done to anticipate and address these potential barriers?"

Note that each question is a "HOW" and "WHAT" question. In addition to collaborative goal-setting, the psychotherapist has an array of alternative ways to incorporate spiritually-oriented activities into the treatment program. These include:

- Systematically assess for the client's religious beliefs and activities and determine how faith and spirituality have been used as a coping activity (See Pargament et al., 1988)
- Refer to scripture or use religious metaphors as teaching examples. Can refer to religious figures such as Christ, Buddha, Maimonides as examples of a treatment approach. For examples Maimonides suggested that individuals overcome their fears by engaging in "opposite" behaviors (a form of modern day exposure therapy), so they can develop a "golden path"(see Huppert and Siev, 2010).
- Use metaphorical devices as an example of how the clients' religious beliefs may act as a "trap" (e.g., Use of the toy such as a Chinese finger trap; conveying metaphorical account of falling into a ditch and trying to get out by shoveling frantically) - - (see Hayes et al. 2006).

- Propst (1998) has developed a cognitive therapy protocol that includes religious rationales for the treatment approach, religious arguments to counter dysfunctional thoughts, religious imagery procedures and religious motivations for behavior change. For example, Propst encourages clients to use mental rehearsal of an anticipated event of imagining Christ is with you in the situation and engages in healing remembrance activities. Guido (2004) holds healing remembrance activities involving religious services, sermons, homilies and prayers that speak of redemption.
- Weisman et al. (2010) have incorporated a three session Spiritual Coping Module in their culturally-informed treatment of schizophrenia that includes providing a rationale for including religion/spirituality in treatment highlighting the potential benefits; the assessment of religious experiences; an “exploring of spirituality” Handout; and family involvement in discussing their use of spiritual coping strategies. The role of “Spiritual Pillars” such as forgiveness, empathy, appreciation and peace are then discussed. The family and the client create a “family tree” illustrating the ancestral history of religious and spiritual traditions. Other intervention activities include reading spiritual bibliotherapy and the family is encouraged to engage in spiritual practices (e.g., church attendance, prayer, scripture reading).

Spiritual interventions have been effectively incorporated into a variety of evidence-based cognitive-behavioral (CBT) and Acceptance and Commitment Treatment (ACT) approaches. For example see Spangler (2010) who has blended spirituality and CBT for patients with eating disorders; Huppert & Siev (2010) who have focused on obsessive compulsive scrupulosity (obsessional fear of thinking or behaving immorally); and Karela and Constantinou (2010) who used ACT and spirituality to treat cancer patients. For example, Spangler (2010) supplemented Fairburn’s (2008) cognitive behavioral treatment of eating disorders with such spiritually-based interventions as mindful eating and body compassion exercises, challenging clients’ thoughts and beliefs using religious metaphors, value-based interventions (use of pie charts, legacy writing exercise), body scan meditation and forgiveness activities.

- Train clients in mindfulness and acceptance skills of learning how to develop a detached, nonjudgmental observing style that focuses attention on experiencing in the present moment. Train clients on how to witness and accept, rather than avoid and interpret their thoughts. Psychotherapists use varied metaphors to describe these mindfulness skills.

“It is like floating on a raft in the ocean and you are absorbing the warmth of the sun, noticing and accepting the rolling waves you are feeling under your floating raft.”

“Think of your mind as a conveyor belt, watching thoughts and feelings that flow by without evaluating them, nor having to change them in any way.”

“It is like watching clouds go by.”

“In the same way you do not believe everything you read in a newspaper, you don’t have to believe every thought that you have.”

There is evidence that people who have trained to achieve mindfulness are better attuned to their emotions, have greater capacity for self-regulation, and have a higher sense of well-being (Brown & Ryan, 2003; Brown et al., 2007). See Baer (2003); Becker and Zayfert (2001); Gerner et al. (2005), Hayes et al (1999, 2005), Kabat-Zinn (2003), and Segal et al (2002), for a discussion of how mindfulness activities can be integrated into spiritually-oriented psychotherapeutic interventions.

- Use religious methods in a culturally-sensitive fashion. For example, with Native American populations, Silver and Wilson (1998) have described how healing and purification ceremonies such as a Sweat Lodge ceremony, chanting, drumming, and sharing have been used to treat individuals experiencing combat stress reactions and PTSD.
- Explore whether the client wishes to engage in religious activities of prayer, attending religious services, meditation, Bible reading, rituals, confession, repentance, engage in candle light vigils, play religious music.
- Pray with the client in the session.
- Pray for the client.
- Encourage the client to engage in **forgiveness activities** of oneself, others and God (see McCullough et al. 1998, 2000; Worthington’s 1998 Pyramid Model of Forgiveness and Wade & Worthington, 2005). When considering forgiveness, there is a need to draw a distinction between forgiveness and justice. One can forgive in order to be freed from the burdens of resentment, revenge and despair. Forgiveness can be beneficial for the victim, as well as the perpetrator, and it does not mean that justice cannot and should not be served. Forgiveness is not synonymous with condoning, excusing, forgetting, tolerating or denying the wrong-doer's behavior. A cautionary note about how to incorporate forgiveness activities into psychotherapy was sounded by McKay and his colleagues (2007) who highlighted a feminist empowerment model of forgiveness psychotherapy. They underscore the need that female clients view forgiveness as an informed choice and not a gender-related mandate, where they suppress legitimate anger.

Worthington (2005) proposes that both human and divine forgiveness depends on empathic identification with the transgressor as a form of releasing oneself, or giving oneself permission to give up anger and vengeance. An illustration of this approach was offered by Johnson (2001). He recommended that a psychotherapist could comment to the client.

“How is one forgiven in your faith?”

“Are you saying that God wants you to suffer the rest of your life because of X?”

“Is there nothing in your religion which teaches that humans can make mistakes? Is mistake-making part of human nature? People can be forgiven and redeemed for their mistakes. Is that part of Jesus’ message?”

“Yes, your religion teaches us..., but correct me if I am wrong, it also teaches us...”

“According to your religion, wouldn’t you say that you are a person who ..., but who is still invited to be forgiven?”

“Jesus made it clear in the Bible that all sins will be forgiven if you seek forgiveness and believe in Him. How is it that you can say you are fallen?”

“What do the prophets say about...?”

“For those who successfully employ forgiveness activities, they often report that ‘a weight has been lifted from their shoulders’; ‘a toxic source is now gone from within them’; ‘God has worked through them to serve others and give up anger’.”

When considering such forgiveness activities it is critical to keep in mind that forgiveness is not equally valued by all. Forgiveness is more difficult when severe hurt is involved. The client may misperceive the request for forgiveness as the minimization of brutality.

An interesting discussion of intergroup negotiated forgiveness in settings of political violence has been offered by Roe (2007) in the Peace and Conflict Journal.

- Provide the client with religious materials to read or use religious bibliotherapy or guide the patient to religiously-based Websites (e.g., Frankl 1963; Kushner, 1981).
- Encourage clients to participate in religiously-based treatments such as Alcoholics Anonymous.
- Encourage clients to focus on the world to come.
- Talk to the client’s pastor, priest, rabbi, Iman, local healer. Invite clergy to be a co-therapist (e.g., see McMinn et al., 1998). This should only be done with the client’s permission.
- Therapists can convey their own “spirituality” to their clients. Comment on resilience of humanity, courage of the human spirit, use a journey metaphor (Phoenix rising) or the metaphor of equating coming to a new land is like a "rebirth", or the use of language of "becoming", joy in participating in the healing of others, and ways to nurture personal growth.

- Use the client's faith as a way to come to a resolution, come to terms with events and their implications, search for a meaningful perspective. For example, Yalom (1980) invites clients to write two obituaries of themselves indicating the way they want to be remembered (current way they are living versus ideal way they would like to live). Such existential exercises are designed to have clients reevaluate and reprioritize values and personal strivings. Hayes et al. (2006) use Acceptance and Commitment Therapy procedures that focus on the client's values. They encourage the client to write two "epitaphs" as it may currently read and the one that they would like to have written.
- Another area where religion and spirituality has been employed is that of domestic violence. Fall and Howard (2004) indicate that some batterers, have used their religious views as ways to justify their controlling behaviors. In their workbook for treating batterers they include exercises to challenge such views and they highlight Biblical scriptural passages that nurture supportive, compassionate gender relationships. Additional references on spirituality and abuse include Cassidy-Shaw (2002), Conners et al. (2003), Horton and Williamson (1988), Kroger & Beck (1996), Kroeger & Nason-Clark (2001), Miles (2000); Worthington et al. (1990).
- Drescher et al. (2004) and Foy et al. (2011) have blended spirituality into manualized trauma-focused group therapy. In the eight session-by-session meetings, the themes included a discussion of spirituality as an "attempt to connect to something outside of self"; building connections; enhancing spiritual practices such as "giving back" through community service; resolving spiritual struggles; considering forgiveness; redefining personal values as reflected in day-to-day behavior and reconnecting with one's religious and spiritual roots and traditions from childhood and finding meaning and ways to matter to other people.

X. ADDITIONAL SPIRITUALITY-ORIENTED PSYCHOTHERAPEUTIC INTERVENTIONS

How can therapists use metaphors, analogies and story-telling as a way to help victimized individuals become “unstuck” and reframe events?

Psychotherapists are good “story tellers” and they incorporate metaphors and analogies in their stories in a timely and judicious fashion and in a manner that is personally-relevant to the individual being helped. The psychotherapist can use the client’s experience to select the relevant metaphorical example and spiritual activities that nurture hope and help individuals get “unstuck” from the negative impact of having been victimized. Consider the following examples that therapists can use with clients.

1. “One of the rewards of being a therapist is being able to bear witness. I like to think of myself as a kind of a biographer or as a kind of archivist. You know the person who keeps the records of personal growth, the record of personal milestones.” The therapist can offer examples of the client’s courage and resilience. The therapist can comment on the client’s records and milestones, or better yet, ask the client to suggest what are some of the things that you, the therapist, might have recorded in your therapy notes that documents the client’s resilience and courage. The therapist can comment on being impressed and inspired by the client’s struggles, determination, survival skills and the successes that he/she has been able to achieve “in spite of”
2. Compare someone who has experienced a traumatic event(s) as being like someone who emigrates to a new land and must build a new life within a new culture from the one left behind (Herman, 1992). Ask the client to apply this analogy to his/her experience.
3. Ask the client if you the therapist, can make a “gift” of the client’s “story of survival and resilience” with others , without disclosing the client's name or in any way violating the client’s privacy.
4. “Crisis means a change in the flow of life - - when the river flows relentlessly to the sea; when it reaches a point where it is blocked by rocks and debris, it struggles to find ways to continue its path. Would the alternative be to flow backwards? That is what a person in crisis craves, to go back in time. But life doesn’t provide a reverse gear, and the struggle must go forward, like the river, with occasional pauses to tread water and check out where we are heading.” (Kfir, 1989, p.. 31)
5. When the roots of a tree hit a large stone or other obstacle, do they try to shove the stone away or crack it? No. The roots just grow around the obstacle and keep going. The stone may have interrupted or slowed the tree’s growth for a while, but no stone, no matter how large, can stop the tree from growing. (Stone symbolizes obstacles to personal growth.) (Matsakis, 1992, p. 133)
6. In order to illustrate the stubbornness and stuckness of peoples' coping strategies Dolan (1991, p. 74-75) tells a story about the Titanic sinking and the Captain’s stubborn

insistence that nothing was wrong. “Full steam ahead, as if nothing happened, may have actually caused the Titanic to sink faster.”

7. As reported by Kingsbury (1992), Milton Erickson compared therapy to a process where clients get by a “log jamming a river”. The therapist metaphorically can kick the “right log” and help the client become unstuck so the mass of logs will move.
8. Addictions may be viewed as a “False God,” or as a form of misplaced faith, that one has embraced and one has to use one’s faith to find the “True God”.
9. Kfir (1989, p. 38) offers the **Biblical stories of Job and King David** as healing metaphors. This is especially useful with clients for whom the Bible has some psychological presence and who are struggling with “why” questions.

“Consider two biblical figures who suffered tragedies, Job and King David. Job’s tragedies were monumental and included the loss of his family and fortune and his bout with leprosy. In the face of these big losses he despaired. (Why?) He could not go on with life unless he understood why those things happened to him.

King David likewise suffered greatly. Persecuted by King Saul for years he fled into the desert. He lost his baby for his sins, lost his most beloved son, Absalom, who led the mob against him, had to give up his dream of rebuilding the Temple as a punishment for the bloodshed, and, in the end, lost his best friend Jonathan. In spite of all that King David was never in crisis. (Why?) He did not ask God for explanations. He took what life dished out to him and went on with living.”

10. Kathryn Hanson Carroll (M. Div), a Lutheran Minister, who was on the Board of the Melissa Institute has offered several other examples of how **stories from the Old and New Testaments** can be used to comfort, inspire and guide victims of trauma.
 - In Christian circles, individuals can find strength and comfort from the person of Jesus. Victims can be reminded that God identifies with struggle and isolation. For God has had the full range of human experiences through Jesus. This can offer a sense of solidarity with a God who understands and can respond to “brokenness”. People may find further comfort and strength in recognizing that Christ loved them enough to die on behalf of them.

Matthew 12:28-30

"Come unto me, all ye that labor and are heavy laden, and I will give you rest. Take my yoke upon you, and learn of me; for I am meek and lowly in heart; and ye shall find rest unto your souls; For my yoke is easy and my burden is light"

- The letter of Paul to the Philippians reminds people that struggle is part of human experience and that one can survive and find joy, even when

imprisoned (**II Corinthians 11**). The power of hope in suffering can also be found in **Romans 5:1-5**

- Scripture highlights the sense of being accepted, no matter what one has endured.

Isaiah 43:4 *“Because you are precious in my sight, and honored, and I love you”*

Jeremiah 29:11-13. *“For surely I know the plans I have for you, says the Lord, plans for your welfare and not for harm, to give a future with hope. Then when you call upon me and pray to me, I will hear you. When you search for me, you will find me; if you seek me with all of your heart.”*

“I have learned to find resources in myself whatever my circumstances” (**Phil. 4:11**) and *“Blessed are the merciful”* (**Matt. 5:7**).

- The narrative of Joseph, with the culminating verse in **Genesis 50:20**, spoken by Joseph to his brothers, who had sold him into slavery years earlier, underscores that God can use evil for good purposes.

“Don’t you see, you planned evil against me, but God uses these same plans for good.”

The story of Joseph serves to remind victims that ultimate meaning to a negative (or positive) event should not be assigned immediately. It was years before Joseph could see God’s gracious hand active in the negative acts of his brothers. It does not mean that one needs to feel happy about the experience, but it does suggest that good things may stem from it.

- The isolation that some victimized individuals may experience or individuals with illnesses like AIDS may be compared to the isolation felt by sufferers of leprosy in ancient times. Stories such as Jesus healing the lepers in **Luke 5:12-13** highlight the compassion of God for sufferers.
- The **Book of Psalms** that deals with the full range of human emotions of grief, guilt and anger toward God can be helpful and comforting. These poems can also serve as “permission” to be honest with one’s feeling in the face of God. They also can give voice to someone struggling for words to describe an emotional state. Examples include **Lamentation Psalms 6, 13, 22; Imprecatory Psalms - 39;109; Penitential Psalms - 51, 130, 143. Other Biblical passages for times of trouble include:**

“Though I walk through the valley of the shadow of death, I will fear no evil, for thou art with me” (**Psalm 23**).

“Weeping may endure for a night, but joy cometh in the morning” (Psalm 30:5).

11. Hoyt (1994) describes how a ritual can be used to help a victimized client deal with the lingering impact of an abusive father. The psychotherapist helped the client to become “emotionally divorced” from her abusive father by engaging in a ritualized spiritual ceremony. With the help of her husband, the client read a prepared biographical statement, played carefully selected music, and then burned her father’s photograph. A “decree of divorce” was signed and witnessed, followed by a brief celebration. The client felt as if she had completed a “Chapter in her life.”
12. Jay (1994) reminds victimized individuals that their traumatic memories are not to be forgotten, but rather **contained** and **sanctified**. He provides a number of healing metaphors.

“Your payers bind your loss to the losses of your people. Your personal trauma becomes resonant (one with) history and part of a life cycle of recovery.”

“Trauma shatters the connection between one’s soul and one’s world. By recalling, one can ‘mend’, ‘repair’, ‘transform’, and ‘bring together shattered pieces.’”

“Trauma should not occur in isolation, nor should its suffering.”

“Rituals cyclically connect personal tragedy with the rhythm of religious life as the ceremonies stitch and restitch a tear that can never fully be mended and that needs constant repair.”

“We need a ‘wall of wailing’ for the aching hurt of trauma; a place for the offering of memory; the declaration of self-hood, and the needed response of others. We need a place and a way for individuals to give further voice of their knowledge of dread, instead of hearing it alone in nightmares.”

13. Meichenbaum (1994) has reviewed several ways Art Expressive techniques, metaphorical story telling and cognitive-behavior play therapy can be used to help traumatized children and their families. Also see Cohen, Mannarino and Deblinger (2006) and Websites www.musc.edu/tfcbt and www.nctsnet.org for examples of how to how to conduct Trauma-focused cognitive-behavior therapy. The spiritually-oriented interventions in this **Handout** can be used to supplement these psychotherapeutic interventions, as illustrated by Kataoka et al (2006).
14. Kataoka et al (2006) describe how a faith-based community intervention can be used to treat children who have been exposed to violence. The need for such an intervention was

highlighted by the high incidence of violence exposure, especially in minority, urban, poor populations.

“Violence exposure before 6th grade is associated with higher rates of school suspensions and expulsions and lower rates of attendance. Results of a survey of 2800 6th grade students suggest that the traumatic effects of violence appear to account for 50% of the learning gap experienced by students” (Kataoka et al, 2006, p151-152)

Such victimized students are also likely to develop symptoms of PTSD, depression, anxiety, substance abuse disorders and aggressive behaviors. Most of these children do not receive any form of treatment.

Kataoka et al. demonstrated how a Cognitive-behavioral Intervention for Trauma in Schools (CBITS) could be integrated with a faith-based approach in treating these victimized children. The CBITS was complemented with religious coping strategies such as prayer, religious imagery incorporated in relaxation exercises, letting go of anxiousness through faith, using Latino health practitioners and parish nurses (promotoras), and incorporating a religious rationale, rituals and services as ways to counter maladaptive thoughts and feelings. The CBITS intervention also involved the children’s parents and the intervention was sensitive to the spiritual lives of the children and parents, so their faith was seen as a means of getting through adversities. As one mother observed:

“My boy was very afraid and from that day he was terrorized. He wouldn’t go outside. I remember at night he would pray and ask Jesus to give him comfort” (as reported by Kataoka et al, 2006)

14. Use Hymns and spirituals that have resilience themes.

Amazing Grace

“There is a balm in Gilead to make the wounded whole. There is a balm in Gilead to heal the sin-sick soul.” (Hymn)

“I shall not, I shall not be moved. Just like a tree planted by the waters, I shall not be moved.”

“Precious Lord, take my hand.”

“After you’ve done all you can, you just stand and let God see you through.”

XI. FURTHER EXAMPLES OF THE INTEGRATION OF SPIRITUALITY AND CULTURE INTO PSYCHOTHERAPY: LATINO HEALING AND OTHER CULTURAL PRACTICES

Lillian Comas-Diaz (2006) has observed that “spirituality permeates Latino life”. Latino everyday language is filled with invocations of God, angels and saints with multiple references to “God willing”. Spirituality which is communal in Latino culture can provide sustenance, hope, a sense of belonging, and a reason to live. Comas-Diaz provides a number of examples of Latino healing procedures that culturally-sensitive and culturally –competent psychotherapists can include in order to help traumatized clients develop spiritual resilience and move from being “sufferers to seekers”. These healing procedures may include:

- Conduct assessment of culturally-specific distress. For example, among Mexican American “nervios” that center on various somatic sensations of shortness of breath and trembling which are thought to indicate dysregulation of nerves or called “ataque de nervios” among Puerto Ricans. See Hinton et al. (2006) who highlight the need to provide information designed to dispel misinformation and myths.
- Use of imagery and fantasy in therapy (see De Rios (1997) who uses “magical realism”, which is a mixture of reality and fantasy. Cultural heroes and heroines are used to help traumatized Latino children image safety and reconfigure traumatic events).
- Use religious rituals such as a visit to a sanctuary, engage in communal rosaries, novenas, posadas, peregrinations, purification ceremonies that seek to destroy the “sick existence” and experience a new life, and find comfort and meaning in Our Lady of Guadalupe, reinforcing a cosmic locus of control expressed in reference to “God’s decision”
- Call upon spiritual and existential wisdom -- “sabiduria”. Honor ancestors and value intergenerational wisdom. In Latino culture there is boundary permeability that may extend beyond death. The deceased can continue a relationship with the living through dreams, visions, visitation, and through the intercession of folk healers.
- Use Spanish proverbs or “Dichos” which are culturally accepted communications that discourage the expression of negative feelings and can act as learning tools for cognitive restructuring. Dichos foster cultural resilience, transcendence and rebirth. Life’s setbacks are viewed as opportunities for spiritual development.

Illustrative Dichos

“When one door closes another one opens”

“A bad thing can turn into something good”

“God helps those who help themselves”

- Use storyteller icons, folktales, folk tapestries to create personal narratives that lead to healing and transformation (See Agosin, 1996; Ginaturco & Turtle, 2000).
- Reaffirm bonds to one's group, ancestors and offspring. Attend celebrations, ceremonies, communicate with dead relatives, repeat story of namesake. Comas-Diaz indicates that Latino clients may invite the psychotherapist to attend and participate in such celebrations.
- Conduct dream analysis and art expression practices (See Cane, 2000).
- Engage in testimonial activities that may lead to political activities (See Agger & Jensen 1990, Meichenbaum, 2012)
- Conduct culturally-appropriate burial rites. Connection among People of Color transcends death. For many Latinos, affiliation with dead relatives through dreams, visions and feelings helps them cope with grief. Likewise, some Asian American groups value their connection with their ancestors. Native Americans view the relatives who have gone before them as part of their lives and relationships with ancestors help to guide present-day actions.
- Consult a folk healer who may act as an adjunct to the psychotherapist in order to nurture a sense of harmony in the client's mind, body and spirit. The folk healer may use purifications rituals, herbs, prayer, community ceremonial activities to foster healing. The client may choose to communicate with God directly without the intercession of a folk healer. (See Brave Heart, 1995)

These varied activities indicate that “**spirituality is at the base of Latino healing**”.

Several other psychotherapists who work with Latino populations have also demonstrated that treatment can be culturally adapted and involve spiritual elements. For example:

- Organista et al (1994) and Munoz and Mendelson (2005) have culturally adapted cognitive behavior therapy to treat Latino depressed outpatients.
- Costantino et al (1986, 1994) have used story-telling and folktales (Cuento Therapy) with Puerto Rican children.
- Koss-Chioino and Vargas (1999) have demonstrated how restoring a spiritual connection helped Latino youth who were struggling with psychological and acculturative distress, alienation and substance abuse.

Among many **AFRICA AMERICANS** the “Church Family” and “Church Home” are a major source of coping skills and social supports. The role of Black churches in trauma response and as a source of strength in the face of racism and discrimination needs to be accessed. As Nancy Boyd-Franklin, in a Melissa Institute conference on cultural diversity (*see www.melissainstitute.org*) highlighted, Black churches provide a variety of

instrumental, emotional and spiritual supports, whether it is in the form of hymns, spirituals, Gospel song, memorial funeral services, or mental health interventions following natural disasters, violent acts and racist acts. Black churches are often a focus point in communities and can help normalize and reframe any emotional expressions as “tears of strength and love.” Boyd-Franklin admonishes the need to establish relationships with Black churches in the community prior to a disaster.

In terms of cultural sensitivity, it has been observed that it is commonplace to say that “Japanese are born Shinto, marry as Christians and die as Buddhists.” This observation highlights how important it is to be sensitive to variations even within a cultural group.

XI. TREATMENT OF SUBSTANCE-ABUSE DISORDERS - - ROLE OF SPIRITUALITY TREATMENT OF ALCOHOL ADDICTION: GENERAL FINDINGS

Research comparing individuals receiving alcohol treatment with those receiving no treatment have found low treatment efficacy. (Imel et al.2008)

Conventional treatment may lead to short-term success; long-term studies indicate that improvements are significantly reduced over time.

Relapse rates are high with the majority of clients having resumed pretreatment levels of alcohol use at one-year posttreatment.

Self-help therapy such as 12 Step AA has been found to be as or more effective and less expensive than traditional therapy conducted by professionals. (Emmelkamp & Vedel, 2006; Ferri et al. 2006; Groh et al. 2008; Timko et al. 2006). As Van Dam et al. (2012) observe:

“The treatment results of the twelve-step approaches are comparable to other evidence-based treatments for alcohol-use disorder” (p. 204).

With these findings in mind, let us consider the possible change mechanism of the most widely subscribed intervention of Alcoholic Anonymous which is estimated to have over 2 million members in 150 countries. Researchers have pointed to mechanisms of spirituality, self-efficacy, coping and social supports.

ROLE OF SPIRITUALITY

AA is steeped with spiritual references. As Denton (2007) observed,

“Five of the twelve steps of AA explicitly mention God. All other steps except the first imply God or ‘a higher power greater than ourselves’ are a necessary component in the task of recovery from substance abuse. The last three steps make the point that mending the damage from substance abuse and managing life as a now clean addictive person is a life-long journey of care, rather than merely a way station in one’s life” (p185).

AA treatment focuses on enhancing clients' views that their substance addiction is a "disease" and that one should use the AA program and the fellowship of AA as a means of recovery (Nowinski, 1999). For example, other steps in AA recovery include Self-examination embodied in Step 4, Confession which follows next in Step 5, and Surrender that takes Steps 6 and 7. The "Searching and moral inventory" of Step 4 lays the groundwork for the Acknowledgement of personal responsibility and their roles in contributing to any personal failures (Step 10).

"An effective Tenth Step is telling oneself, God and another person that I am resentful because I feel threatened or

disappointed, or hurt because of my own selfishness, pride, envy or greed" (Denton, 2007, p186).

Step 11 directs participants to focus their essential status as a "child of God". Participants are encouraged to accept "the knowledge of His will and the power to carry it out". Step 12 admonishes that there is a need "to practice these principles in all of your affairs". There have been multiple personnel testimonies of the effectiveness of such self-help interventions. For example, when the actress Jamie Lee Curtis was asked by Larry King what made you get clean from drugs, she answered:

"Well, you know what, that turning point was a-- was really between me and God and I never went to formal treatment. I walked into the door of a 12 Step program and I have not walked out since."

However, in a critical review of 12 Step AA programs, McCrady and Nathan (2006) observe that the exact role that spirituality plays in the recovery process in AA has not been determined. A straight forward comparison of the relative efficacy of AA and of a non-spiritually-oriented intervention like Secular Organizations for Sobriety (SOS) or SMART RECOVERY has not been conducted. The closest comparison comes from the Project **MATCH** study that compared three time-limited outpatient treatments (Cognitive-Behavioral Coping Skills Treatment, Motivational Enhancement Therapy and 12-Step Facilitation). The Project MATCH Research Group (1998) reported a comparable reduction in the number of drinking days of more than 70% for all three groups, but at follow-up, some 39 weeks later, across the three treatment groups only 40% were completely abstinent. Overall, Project MATCH reported no significant difference among the three treatments, but the Twelve-step Facilitation group was more effective in inducing clients to maintain continuous abstinence during follow-up.

In Project MATCH the 12-Step program was administered as an outpatient basis, once weekly treatment for 12 weeks. Such 12-Step programs are more typically delivered on a more intensive fashion where clients participate in several hours of group meetings several days a week. As McCrady and Nathan (2006) observe, this more intensive AA treatment has not been evaluated in randomized clinical trials.

The 12 Step AA intervention program teaches clients a variety of coping skills including how to:

- 1) think about the negative consequences on health, well being and social relationships when tempted to drink;
- 2) manage life problems by focusing on introspection, prayer, meditation, making amends, and reaching out to others (e.g. calling other AA members or one's sponsor);
- 3) structure one's time by attending AA meetings and activities;
- 4) alter one's life-style and nurture affiliation with sobriety-supporting peers, coworkers and family members, and thus experience more reinforcement from

- a substance-free social environment;
- 5) appreciate that it is possible to live happy, productive lives without alcohol, thus changing their perceptions of social norms;
- 6) actively promote increases in self-efficacy for meaningful change in the substance-abusing life-style.

As McCrady and Nathan (2006, p. 331) observe:

"For example, Morgenstern et al. (1997) demonstrated that 12-Step approaches seem to work by maintaining abstinence, while Connors et al. (2001) reported that the positive relationship between AA participation and frequency of abstinence days found in Project MATCH treatment samples 7-12 months post-treatment was mediated by perceived self-efficacy to avoid drinking".

The research indicated that it was not changes in the spirituality that predicted outcomes. Rather it was the nature of the "stories" that clients told themselves and others that reflected both self-confidence and personal efficacy that seemed to mediate behavioral changes and abstinence. As one AA member observed:

"Perhaps, I am not a lost cause after all. There is hope and with the help of others I can stay sober".

If it is not spirituality per se that mediates change that results from AA participation, then an alternative mediating mechanism may be changes in social support.

THE ROLE OF SOCIAL SUPPORT

Groh, et al. (2008) highlight that AA encourages members to:

- (1) incorporate AA principles into their lives;
- (2) compile a list of people they have harmed and made amends to those individuals;
- (3) change pretreatment networks who encouraged substance abuse;
- (4) encourage significant others to participate in AA activities such as Al-Anon.

AA involvement also

- (5) advocates positive changes in social supports and improved friendship quality, greater friend support, getting support for abstinence by friends;
- (6) encourages adding positive 12-Step friendships using networks, since individuals who maintain substance-using networks, are more prone to relapse;

- (7) encourages providing assistance to others which is a valuable part of recovery (namely, “help the helper” model);
- (8) fosters a sense of trust and purpose and shifts the focus from self to others. Participants are encouraged in the 12th Step to focus on service and bringing the message of AA to others;
- (9) encourages and reinforces a healthy life-style of sobriety that is nurtured by the formulation of healthy friendships, quality social time and sober activities. AA sponsors and AA friends share recovery experiences and coping techniques designed to provide specific support for maintaining abstinence.

As Groh et al. (2008) concluded:

***“The current body of literature clearly demonstrated that AA involvement leads to more positive friendship resources and produces larger social networks containing others in recovery who provide support for abstinence. Many of these significant effects were only found for friends, which is not surprising given the focus of AA and the more flexible nature of friendships, as compared to family. In addition, support for abstinence had the greatest impact on abstinence when provided by others who are in AA.*”**

Interestingly, individuals who have the worst social support network, namely significant others who supported drinking, had the best outcomes in AA. Social support by AA members, as opposed to non AA members, had a greater impact.

There is value in encouraging alcoholic clients to attend and participate in AA “network therapy” that results in a change in their social contacts. This appears to hold no matter what their spiritual or religious beliefs may be (See Tonigan et al. 1996 and Winzelberg & Humphreys, 1999).

12 STEP AA PROGRAM CHECKLIST

Donald Meichenbaum, Ph.D.

Alcohol Anonymous, AA is an International Program with 97,000 AA groups and a total of 2 million members who attend yearly. Since many Treatment Centers have adopted the AA treatment group approach, there is a need for all therapists to be familiar with their 12 Steps and their language and treatment culture. The following examples of 12 Step Activities can be blended with various cognitive-behavioral treatment approaches. (See Knack, 2008)

The therapist can use the following **Checklist of AA Activities** and accompanying **AA Beliefs** with clients. The therapist can ask clients to fill in the **Checklist** in order to:

2. Assess what AA activities clients have already engaged in and what AA beliefs they have embraced.
3. Assess the reasons why clients have or have not engaged in these activities (possible barriers, lack of motivation, confidence, skills, opportunities) and how these obstacles can be addressed.
4. Engage would-be participants to join AA and treatment, highlighting what new members may get out of some form of treatment.

AA BEHAVIORS

How many of the following behaviors do you presently practice? Please put a check mark next to each behavior that you now do as a result of participating in the 12 Step AA Program.

1. Attend AA meetings (Beginner's meeting, Big Book meetings, 12 Step meetings).
How often per week?
2. Identify with presenters, but not compare myself to them. Now I do not feel so alone and different any more.
3. Follow a schedule that makes life feel ordered.
4. Work my program. Work toward progress, not toward perfection.
5. Be open, honest and helpful to others.
6. Tell my story of "What it was like to be dependent on drugs, what happened and what it feels like now".
7. Surrender to a Higher Power (namely, a Spiritual Force, a deity, my sponsor, my group) and thus, regain control.
8. Get a sponsor, a home group, get involved and begin working the Steps.
9. Call my sponsor daily.
10. Increase my awareness and watch out for triggers. (Social pressure, interpersonal conflict, strong emotions such as anger, resentment, depression, loneliness, boredom).
11. Use my self-soothing and self-regulation behaviors. Control my emotions.
12. Look at my beliefs (e.g., a sense of entitlement, viewing people as doing things to me "on purpose") and see how these beliefs can contribute to my addictive behavior.

- _____ 13. Put my experiences into words and share my thoughts and feelings with my sponsor and with trusting others.
- _____ 14. Cut down on my self-criticism and perfectionism. I can learn to forgive myself.
- _____ 15. Use my coping behaviors to manage threats to my self-esteem (pride, “ego”).
- _____ 16. Ride out and procrastinate (delay) my cravings and desire to use substances.
- _____ 17. Before I take a drink (use substances), I can look at where my drinking has led me in the past and where it will lead me in the future.
- _____ 18. Think through the drink.
- _____ 19. Hang around with sober non-drinking buddies and family members. Firmly connect with a sober support network, especially at the beginning of the recovery journey.
- _____ 20. Do a Moral Inventory.
- _____ 21. Make amends. Make a list of all the people that I have had a negative impact as a result of my drinking and begin making amends.
- _____ 22. Make a Gratitude List and follow through in showing my appreciation.
- _____ 23. Recognize signs of change and rehabilitation and “take credit” for this change. Use my “change talk” of “notice, catch, interrupt, game plan, backup plan, relapse prevention plan”).
- _____ 24. Keep coming back.
- _____ 25. Share my journey of recovery with others. Make a “gift” of my experiences with others. I can sponsor others.

AA BELIEFS

Please put a check mark next to each belief or self-statement that you now hold, as a result of participating in the 12 Step AA program.

I NOW BELIEVE THAT

Thinking Behaviors

- _____ 26. Addiction is 90% thinking and 10 % drinking. (Some say, 99% thinking and 1% drinking).
- _____ 27. I can look at and begin to change my beliefs that contributed to my drinking (for example, my sense of entitlement and the “shoulds”, “musts”, and “wants” in my life).
- _____ 28. I can be “right-sized” - - not have to be too perfect or “better than”. Comfortable with myself.
- _____ 29. I can recognize that relapse is part of the illness of addiction.
- _____ 30. I can tie my drinking to the trouble in my life and see the beliefs that support my addictive behaviors.
- _____ 31. To be humble is not to think less of yourself, but to think of yourself less.
- _____ 32. I can recall my sponsor telling me, “If you want what we have, do what we do”. This stays with me.

I NOW BELIEVE THAT

Coping Behaviors

- _____ 33. I can remind myself to “take one day at a time”. “Easy does it!”
- _____ 34. I can remember that “This too shall pass”.
- _____ 35. I can tell myself that having short-comings is a sign of being human. I can understand my vulnerabilities. I can forgive myself.
- _____ 36. I can take responsibility for what I do.
- _____ 37. I can consider my options. The program works if I work it, so if I work it, I am worth it.

I NOW BELIEVE THAT

Nurturing Hope

- _____ 38. I can have HOPE
- _____ 39. Change is possible: I do not have to continue as before.
- _____ 40. I can clean house. Clear away wreckage of the past.
- _____ 41. Accept life on life’s terms.
- _____ 42. I can see myself of value to others. Share experiences.
- _____ 43. I can identify signs of resilience. I can give several examples of each of the following
- I can _____
- I have _____
- I am _____
- _____ 44. Other beliefs I learned include _____.

XII. EPILOGUE

As a result of studying and discussing this Handout with colleagues, psychotherapists should be able to address the following questions:

How can you assess your client's spirituality and the role it plays in his/her life?

How can you, as a psychotherapist (helper), incorporate your client's spirituality into treatment?

How can you nurture your client's spiritual coping efforts?

How can you nurture posttraumatic growth so clients come to see new possibilities, personal and group strengths and foster an appreciation of life, spiritual change and new ways of relating to others?

How can you incorporate a Spiritually-oriented Treatment Programs into your treatment regimen? Moreover, how do you intend to evaluate their effectiveness?

What are the barriers/obstacles of integrating spirituality into your psychotherapeutic efforts and how can these be anticipated and addressed?

What are the dangers of highlighting your client's spirituality and how can these be anticipated and addressed?

PLEASE RETAKE THE SPIRITUALLY-INTEGRATED PSYCHOTHERAPYCHECKLIST

WHAT NEW SPIRITUALLY-ORIENTED ACTIVITIES ARE YOU LIKELY TO TRY IN YOUR CLINICAL PRACTICE?

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XV. INTERNET RESOURCES

Duke Center for Spirituality, Theology and Health

<http://www.dukespiritualityandhealth.org/research.html>

Spirit Research

<http://www.SpiritResearch.org>

Psychotherapy and Spirituality Institute

<http://www.mindspirit.org/>

Psychology of Religion Pages

<http://psychwww.com/psyrelig/index.htm>

Spiritual Self-schema Therapy (3-5)

www.3-s.us

SAMHA Website on Faith-based Communities

http://www.samhsa.gov/fbci/fbci_pubs.aspx
