

**UNDERSTANDING RESILIENCE IN CHILDREN
AND ADULTS: IMPLICATIONS FOR PREVENTION
AND INTERVENTIONS**

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We begin with a brief consideration of the definitions offered of resilience.

DEFINITIONS OF RESILIENCE

(See Luthar et al., 2000; Masten & Reed, 2002; Rutter, 1999)

Resilience refers to a class of phenomena characterized by good outcomes in spite of serious threats to adaptation or development. Resilience has been characterized as the ability to:

- ❖ “bounce back” and cope effectively in the face of difficulties”
- ❖ “bend, but not break under extreme stress”
- ❖ “rebound from adversities”
- ❖ “handle setbacks, persevere and adapt even when things go awry”
- ❖ “maintain equilibrium following highly aversive events”

Resilience is tied to the ability to learn to live with ongoing fear and uncertainty, namely, the ability to show positive adaptation in spite of significant life adversities and the ability to adapt to difficult and challenging life experiences.

As Ernest Hemingway once wrote, *“The world breaks everyone and afterwards many are strong at the broken places”*. In a less poetic fashion, Norman Garmezy, who is one of the founders in the area of resilience research, captured the concept of resilience by asking educators the following question:

“Are there any children in your school who, when you first heard of their backgrounds, you had a great deal of concern about them, and now when you see them in the hall, you have a sense of pride that they are part of your school? ... These are children who cause you to wonder, ‘How can that be?’” (Garmezy in Glantz & Johnson, 1999, p.7)

In short, resilience turns victims into survivors and allows survivors to thrive. Resilient individuals can get distressed, but they are able to manage the negative behavioral outcomes in the face of risks without becoming debilitated.

Such resilience should be viewed as a relational concept conveying connectedness to family, schools, and community. One can speak of resilient families and communities and not just resilient individuals.

ILLUSTRATIVE EVIDENCE OF THE STRESSORS TO WHICH CHILDREN IN THE U.S. ARE EXPOSED

(See Fraser, 2004; Huang et al., 2005; Osofsky, 1997; Schorr, 1998; Smith and Carlson, 1997)

The following illustrative **FACT SHEET** underscores the need to study resilience in high-risk children. This summary does not include the impact of natural disasters like Hurricanes Katrina, Rita and Wilma that occurred in the fall of 2005.

Children Who Suffer From Behavioral and Mental Disorders

- ❖ 1 in 5 children and youth have a diagnosable mental disorder, and 1 in 10 have a serious emotional or behavioral disorder that is severe enough to cause substantial impairment in function at home, at school or in the community.
- ❖ Nationally, children with emotional and behavioral disorders in special education classes have the highest school dropout rate (50%).
- ❖ Mental health problems are associated with lower academic achievement, greater family distress and conflict, and poorer social functioning in childhood that can extend into adulthood. Most forms of adult psychiatric disorders first appear in childhood and adolescence.
- ❖ Only 25% of children with emotional and behavioral disorders receive specialty mental health services.
- ❖ There is increasing evidence that school mental health programs improve educational outcomes by decreasing absences, decreasing discipline referrals and improving test scores.

Children Who Are Maltreated

- ❖ U.S. Department of Health and Human Services (2003) report 3 million referrals were made to child protective service agencies in the U.S. regarding the welfare of approximately 5 million children. Approximately 1 million were found to be victims of maltreatment (physical and sexual abuse and/or neglect). In 84 % of the cases, the perpetrators were the parent or parents. On any given day, about 542,000 children are living in foster care in the U.S. These foster children are at risk for unintended pregnancy, educational underachievement and dropout, substance abuse, psychiatric problems, unemployment and incarceration.
- ❖ 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

- ❖ Every year, 3.3 million children witness assaults against their mothers. For example, in California, it is estimated 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 than adults to be subjects of victimization. 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.
- ❖ 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.
- ❖ “Virtually all” of the inner-city, ethnic minority children who live in 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.

Children Living in Poverty

- ❖ Poverty is a source of ongoing stress and a threat that leads to malnutrition, social deprivation and educational disadvantage. Poverty is associated with an array of problems including low birth-weight, infant mortality, contagious diseases, and childhood injury and death. Poor children are at risk for developmental delays in intellectual growth and school achievement. Sapolsky (2005) has reviewed the literature that indicates in Westernized societies, socioeconomic status (SES) is associated with varied physical and psychiatric disorders as a result of exposure to chronic stressors.
- ❖ 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 3 times more likely than their Caucasian counterparts to be placed in a class for the educable delayed and 3 times 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 school dropout rate in the U.S. is highly correlated with grade retention. On average, two children in every classroom of 30 students are retained.
- e) The school dropout rate for African American students in the U.S. is 39%; 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 negative factors (such as living in poverty, experiencing abuse and neglect, witnessing violence, or being a victim of violence) constitutes high risk for maladaptive 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. In addition, different risk factors often predict similar outcomes.

The cumulative impact of these multiple stressors on children was illustrated by the research of Valerie Edwards and her colleagues 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.

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 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

*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.

NEUROBIOLOGICAL CONSEQUENCES OF CHILDREN BEING EXPOSED TO VICTIMIZATION EXPERIENCES: DEVELOPMENTAL TRAUMATOLOGY

- ❖ Trauma can influence early development and as a result, adults can show evidence of neurobiological changes (DeBellis, 2002; Lipschitz et al., 1998; Ornitz & Pynoos, 1989; Perry, 1994, 1997; Pynoos et al., 1995; Yehuda, 1999; Van der Kolk, 1997; Weiss et al., 1999).
- ❖ Physical abuse and neglect, but not sexual abuse have been associated with the reduction in the volume and activity levels of major structures of the brain, including the corpus callosum (midsagittal area of connective fibers between the left and right hemispheres) and the limbic (emotional regulation) system, including the amygdala and hippocampus.
- ❖ Trauma has been found to affect the HPA Axis (Hypothalamic Pituitary Axis - adrenal axis) contributing to its hypersensitivity to cortisol and can contribute to an increased vulnerability to depression.
- ❖ Trauma exposure can contribute to increased sympathetic nervous system activity which is especially evident under conditions of stress (e.g., increased heart rate and increased blood pressure). This may be manifested as exaggerated startle responses.
- ❖ Among children who have been abused, there is a greater likelihood of cerebral lateralization differences or asynchrony. For example, abused children are seven times more likely to show evidence of left hemisphere deficits. This can contribute to the failure to develop self-regulatory functions, especially language and memory abilities. **Self-regulatory processes** are internalizing, organizing functions that filter, coordinate and temporally organize experience. Self-regulation includes attentional controls, strategic planning, initiation and regulation of goal-directed behaviors, self and social monitoring, abstract reasoning, emotional regulation and interpersonal functioning. Trauma has the most impact when its onset occurs during early childhood and is recurrent or prolonged. **Research suggests that there is impaired left hemisphere functioning in traumatized children.**
- ❖ Trauma exposure results in elevated levels of circulating catecholamines (a group of amines derived from catechol that have important physiological effects as neurotransmitters and hormones) and in abused boys it also results in elevated growth hormone.
- ❖ Trauma exposure can have a negative impact on the development of attachment behavior. For example, abused teenage girls are more likely to hide their feelings and have extreme emotional reactions. They have fewer adaptive coping

strategies and have problems handling strong emotions, particularly anger. Moreover, they have limited expectations that others can be of help. Girls abused as teenagers show deficits in the ability to self-soothe and modulate negative emotions. They show evidence of problems with behavioral impulsivity, affective lability, aggression and substance abuse. For example, Kendall et al. (2000) found that in a twin study, the twin who had been exposed to childhood sexual abuse consistently had an elevated risk for drug and alcohol abuse and bulimia when compared to the unexposed co-twin. Sexual abuse also contributes to increased susceptibility to sexually transmitted disease and can compromise the immune system.

- ❖ In order to compensate for the deficits that arise from multiple victimization experiences and to bolster resilience, special efforts are needed to **bolster** the abused and neglected children's and youth's **self-regulatory systems** and to provide them with "**cognitive and emotional prosthetic devices**" that can help in their development (e.g., metacognitive supports of planning, monitoring, language, memory, as well as social supports).

RESEARCH FACTS ABOUT RESILIENCE

Before we consider how some children and families survive, and perhaps even thrive, in spite of these adversities, it is useful to consider some of the major research findings in the area. These findings can inform ongoing efforts to bolster resilience in high-risk groups.

- ❖ Resilience appears to be the general rule of adaptation. This conclusion holds whether the children who are studied have experienced premature birth, physical illness and surgery, maltreatment (abuse/neglect), are the offspring of mentally ill, alcoholic, criminally-involved parents, exposed to marital discord and domestic violence, poverty, are of minority status and exposed to massive (community level) trauma of war and natural disasters.
- ❖ Research has indicated that 1/2 to 2/3 of children living in such extreme circumstances grow up and “overcome the odds” and go on to achieve successful and adjusted lives (Bernard, 1995). Several longitudinal studies have tracked high-risk children from birth to adulthood (e.g., Werner & Smith, 1989; 1992; also *see* <http://www.kaimb.org/slides/resilience> for a summary of these longitudinal findings).

For example, Emmy Werner and Ruth Smith (2001) studied children who were born on the Hawaiian island of Kauai, most of whom were descendants of Southeast Asians. One of three children were born with the “odds against them.” They were vulnerable due to socioeconomic and family factors (poverty, maltreatment, parental substance abuse and mental illness). In spite of these high-risk factors one child in every three developed into “confident, accomplished and connected adults.”

- ❖ Children may be resilient in one domain in their lives, but not in others (e.g., academic, social, self-regulatory behaviors). For example, children who appear resilient in one domain such as social competence may have difficulties in other domains. As Zimmerman and Arunkumar (1994) observe:

“Resilience is not a universal construct that applies to all life domains. Children may be resilient to specific risk factors, but quite vulnerable to others. Resilience is a multidimensional phenomenon that is context-specific and involves developmental change.” (p. 4)

- ❖ Resilience should be viewed as being “fluid over time.” The relative importance of risk and protective factors are likely to change at various phases of life. A child who is resilient at one developmental phase may not be necessarily resilient at the next developmental phase. Developmental transition points at school and at puberty are particularly sensitive times for the impact of traumas.

- ❖ There is no single means of maintaining equilibrium following highly aversive events, but rather there are multiple pathways to resilience.
- ❖ The factors that contribute to resilience may vary depending upon the nature of the adversity. For example, in children who have been exposed to sexual abuse, having an external attribution style (blaming others or circumstances) may be a protective factor, but this style has not proven as effective for individuals with physical abuse or neglect.
- ❖ Moreover, protective factors may differ across gender, race and cultures. For instance, girls tend to become resilient by building strong, caring relationships, while boys are more likely to build resilience by learning how to use active problem-solving (Bernard, 1995). Further evidence that resilience may yield **gender differences** comes from the research of Werner and Smith (1992). In their longitudinal study of high-risk children they found scholastic competence at age 10 was more strongly associated with successful transition to adult responsibilities for men than for women. On the other hand, factors such as high self-esteem, efficacy and a sense of personal control were more predictive of successful adaptation among the women than men. In the stress domain, males were more vulnerable to separation and loss of caregivers in the first decade of life, while girls were more vulnerable to family discord and loss in the second decade. Thus, the factors that influence resilience may differ for males and females.

This research highlights the need to view resiliency as a developmental construct and the value of studying it longitudinally. *“Resilience is not a trait that a youth is born with or automatically keeps once it is achieved. Resilience is a complex interactive process.”* (Zimmerman & Arunkumar, 1994).

- ❖ Interventions to nurture resilience need to target multiple systems, since research indicates the total number of risk factors present is more important than the specificity of the risk factors in influencing developmental outcomes. For example, Sameroff and his colleagues (1992) studied the influence of social and family risk factors on the stability of intelligence from preschool to adolescence. They found that the pattern of risk was less important than the total amount of risk present in the child’s life.

With these findings in mind, let’s consider the characteristics of resilient children and youth.

CHARACTERISTICS OF RESILIENT CHILDREN AND YOUTH

“The resilient child is one who ‘works well, plays well, loves well and expects well’.” (Bernard, 1997)

- ❖ **Temperament factors** – easy going disposition, not easily upset; good self-regulation of emotional arousal and impulses, and attentional controls. These critically important temperament features may have genetic roots. Kim-Cohen and colleagues (2004) studied resilience among identical (monozygotic) and fraternal (dizygotic) twins who experienced socioeconomic deprivation. They found that MZ twins were more alike showing evidence of resilience (fewer conduct disorder problems than expected given SES stressors) than in DZ twins ($r = .72$ MZ vs. $.26$ DZ twins). Genetic influences explained 71% of variance in resilience. *(See Moffit, 2005 for an excellent discussion of the gene-environment interplay in contributing to resilience.)*
- ❖ **Problem-solving skills** – a higher IQ, abstract thinking, reflectivity, flexibility, and the ability to try alternatives indicate adaptability to stress.
- ❖ **Social competence** – emotional responsiveness, flexibility, empathy and caring, communication skills, a sense of humor (including being able to laugh at themselves) and behaviors that increase their ability to get along with others. They show a general appealingness and attentiveness toward others and an ability to elicit positive reciprocal responses from others. They are able to monitor their own and others’ emotions. Bicultural competence – able to negotiate the cultural divide.
- ❖ **Autonomy** – self-awareness, sense of identity, ability to act independently, ability to exert control over the external environment, self efficacy and an internal locus of control. They have increased sense of self-worth and mastery.
- ❖ **A sense of purpose and a future orientation** – healthy expectations, goal-directedness, future-orientation planning, goal-attaining skills, success orientation, achievement motivation, educational aspirations and persistence; hold religious beliefs that are supported by significant others and that convey a sense of meaning in life (spirituality).
- ❖ **A sense of optimism**, maintain a hopeful outlook and employ active problem-focused coping strategies (They avoid seeing crises as insurmountable problems).
- ❖ **Academic and social successes** - less risk of developing behavioral disorders. (Academic competencies, especially reading comprehension and math skills.) They have talents that are valued by self and society.

PROTECTIVE FACTORS FOR FOSTERING RESILIENCE IN CHILDREN AND YOUTH

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

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).

- ❖ Close affective relationship with at least one 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 convey high expectations in multiple domains
- ❖ Positive family climate with low family discord between parents and between parents and children
- ❖ Organized home environment (role of rituals, ceremonies, shared dinner times 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 are involved in their child's education. Both parents and teachers should convey high, but realistic expectations to their children.
- ❖ Socioeconomic advantages

Within Other Relationships: Extrafamilial Factors

- ❖ Close supportive relationship with prosocial and supportive adult models (role of mentors). Bond to prosocial adults outside family. (*See www.teachsafeschools.org for information on how to establish an adult mentoring program.*)
- ❖ Connections to prosocial and rule-abiding peers who have authoritative parents
- ❖ Support from “kith and kin”, access to wider supports such as extended family members and friends

Within the Schools and the Community

- ❖ “School connectedness” is the belief by students that adults in the school care about them as students and their learning. School connectedness is related to academic, behavioral and social success in school. A protective factor is the attendance in effective schools and being “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?

- ❖ Ties to prosocial organizations, including, schools, clubs, scouting; participation in extracurricular activities.
- ❖ 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 derived from cultural and religious traditions
- ❖ Have extended families who nurture a sense of meaning and identity (connected to larger community by having religious, cultural, community ties)

- ❖ Civic engagement -- 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) show evidence of a wide range of benefits for the students, school and community. (See <http://www.nylc.org>)

For example, a study by the Search Institute asked 10,000 young adolescents to respond to the following:

Think about the helpful things you have done in the last month – for which you did not get paid, but which you did because you wanted to be kind to someone else.

Three quarters of the adolescents spent less than two hours helping others in the previous month; this includes a third of young people in the study who said they had done nothing at all. Only a quarter were involved three or more hours during the previous month. As Brendto et al. (1998, p. 39) observe: “***Volunteer work is not a major force in the development of responsibility in contemporary youth.***”

WHAT CAN BE DONE TO FOSTER RESILIENCE IN CHILDREN IN THE IMMEDIATE AFTERMATH OF A TRAUMATIC EXPERIENCE?

Following exposure to traumatic events, help children to:

- (1) resume normal roles and follow predictable routines, thus maintaining a sense of predictability, safety, control and connections;
- (2) minimize and reduce exposure to upsetting media coverage and process news events with supportive caring adults who can act as models of positive coping;
- (3) engage in "healthy" behaviors (eating, sleeping, and prosocial activities);
- (4) engage in active coping efforts and not engage in avoidant coping activities such as behavioral disengagement (giving up), dissociating, blaming behavior of self or others, angry ruminative behaviors and substance abuse;
- (5) engage in sharing and helping activities with supportive others;
- (6) have parents who are open to talking with their children in reassuring ways about the crisis, but without pressuring their children to talk. (Parents can use occasional "direct questions" about how their child is doing. Resilient children collaborate in formulating a family safety plan for any possible future crises, and they practice these plans with their parents);
- (7) identify and access social supports (people to turn to in the future);
- (8) use faith-based procedures, familial and community rituals to memorialize and grieve as a way to find meaning.

WAYS TO FOSTER RESILIENCE IN CHILDREN AND YOUTH

How Can Social Institutions (Schools, Public Health Departments, Governments, Churches, Families) Nurture Resiliency?

- ❖ Remove or reduce risk factors (unsafe environments, exposure to violence, bullying behaviors).
- ❖ Provide prenatal care.
- ❖ Include better quality of care in infancy (Nutritional programs, Home nurse visiting programs, Infant stimulation programs).
- ❖ Counteract the negative effects of poverty and abuse/neglect.
- ❖ Provide early childhood education – school-readiness programs and bolster protective factors (e.g., see research on vocabulary development on www.TeachSafeSchools.org).
- ❖ Provide adequate medical care on an ongoing basis.
- ❖ Provide good integrative schools with higher SES students – increase the likelihood of academic success and provide graduated mastery experiences. (*See Meichenbaum & Biemiller, 2002 on How to Nurture Independent Learners.*)
- ❖ Create a motivational climate that fosters a “learning for learning’s sake” and reduces student competitiveness. Successes should be measured by improvement.
- ❖ Increase parents’ involvement in their children’s education.
- ❖ Improve the quality of attachment relationships. Provide caring and supportive relationships.
- ❖ Promote competencies, coping skills and general life skills.
- ❖ Increase sense of belonging or bonding to school and achievement.
- ❖ The need to help youth build assets was underscored in research by the Search Institute who have identified some 40 behavioral assets that youth should demonstrate. They identified **20 external** and **20 internal** behavioral assets.

The **external assets** included positive experiences young people receive from the world around them that empower, set boundaries, convey clear expectations about acceptable behaviors and nurture constructive use of time.

The **internal assets** include social competencies, positive values and identities, and commitment to learning. Young people need to experience support, be valued and have opportunities to contribute to others (civic activities), and thus feel empowered.

- ❖ A Search Institute survey of 200,000 6th to 12th graders found that some 56% of young people experienced 20 or fewer of the 40 internal and external assets. These findings emphasize the need to help youth build such behavioral assets (Benson, Galbraith & Espeland, 1998).
- ❖ Help students learn problem solving skills.
- ❖ Use peer-teaching methods. Nurture contact with prosocial peers, and positive adult role models. Help students find social supports. (See Dubois & Karcher, 2005 and *www.TeachSafeSchools.org* for guidance on how to implement mentoring programs.)
- ❖ Provide “second chance opportunities” or help individuals to engage in “niche-seeking” behaviors such as leaving deviant peer groups, engage in athletic, artistic or other activities that provide contact with prosocial adult mentors and peers, participate in military service, engage in positive romantic relationships, attend religious activities.
- ❖ Schools should avoid increasing children’s exposure to risk.. Set up smaller schools since school size is associated with the dropout rate. (See *www.TeachSafeSchools.org* for a discussion of alternatives to suspensions, expulsions and Zero Tolerance programs.)
- ❖ Resilient youth place themselves in healthy contexts, generating opportunities for success or raising the odds of connecting with prosocial peers and mentors. **Help youth find “niches” that foster resilience.**
- ❖ Respect and nurture cultural identities and help enhance self-esteem.

CAN RESILIENCE BE LEARNED?

The answer is a resounding **YES**. There are a number of programs designed to develop, nurture and teach resilience skills. For examples, the American Psychological Association has developed a training program called the Road to Resilience (*www.apahelpcenter.org or call 800-964-2000*) which trains students to develop resilience or “strengthen the mental muscle that everyone has,” using “bounce back” strategies. These may include:

- ❖ Have a friend and be a friend
- ❖ Take charge of your behavior
- ❖ Set new goals and make a plan to reach them
- ❖ Look on the bright side
- ❖ Believe in yourself.

The following list in **Table 2** provides examples of other resilience nurturing programs. See the list of **References** and **Website Links** for illustrative resources and teaching manuals.

TABLE 2
EXAMPLES OF SPECIFIC PROGRAMS DESIGNED TO REDUCE
RISK FACTORS AND BOLSTER RESILIENCE

(See Cohen, 1998; Durlak, 1997; Tolan & Dodge, 2005; Weisz et al., 2005)

Prevention programs that promote strengths of children, parents and schools lead to multiple positive outcomes over time, including reduced mental health problems, substance abuse and high risk sexual behavior. Weisz et al., 2005, p. 634

Visiting Nurse Program	Olds et al., 1998
Perry Preschool Project	Schweinhardt, 2000
Head Start preschool programs	Durlak, 1997
Family support services	Yoshikawa, 1995
Parent-child interaction therapy	Eyberg et al., 2001
Prevent negative consequences of divorce in parents and children	Lee et al., 1994
Wrap around services	Eber et al., 1996; Kamradt, 2000
Child abuse prevention programs	Davis & Gidycz, 2000
Promoting school connectedness	McNeeley et al., 2002
School mental health programs	Jennings et al., 2000
Positive behavior support	Horner & Carr, 1997; Sugai et al., 2001
Drug abuse prevention programs and prevention of school dropouts	Tobler & Stratton, 1997
Creating a caring community	Battistich et al., 1996

EVIDENCE OF RESILIENCE IN ADULTS

When studying how children respond to trauma it is critical to consider how their parents and surrounding adults react. **Research has repeatedly demonstrated that the way distressed parents respond to trauma is an important predictor of the child's response (Meichenbaum, 1997).** Fortunately, most adults also demonstrate resilience in the face of adversity.

- ❖ For individuals exposed to personally threatening and violent physical assaults, approximately 6% - 18% experience chronic Post Traumatic Stress Disorder (PTSD); approximately 13% of Gulf War veterans and 16% of hospitalized victims of motor vehicle accidents experience chronic PTSD.
- ❖ Roughly 50% - 60% of the adult population in North America are exposed to traumatic events, but only 5% - 10% go on to develop maladjusted PTSD and related problems. For example, following the September 11th terrorist attack in New York City, only 7.5% of Manhattan residents had diagnosable clinical problems, and this dropped to .6% at six months. Given the horrific events, this is an impressive finding (Bonanno, 2004). Also, see Schuster and Stein (2001) and Sheehy (2003).
- ❖ Many individuals exposed to such traumatic events will show evidence of short-lived PTSD or subsyndromal reactions that abate over the course of several months.
- ❖ In fact, 40% of Manhattan residents did not report a single PTSD symptom.
- ❖ Further evidence of **resilience in adults** was offered by Rubin and his colleagues in London, England following the subway bombings on July 7, 2005. They assessed the psychological needs of people who were intimately caught up in the bombings through direct exposure or bereavement. They found that less than 1% of respondents had sought professional help for their negative emotions and only 12 respondents felt they needed such help. On the other hand, 71% had spoken to friends or relatives about the attacks, a **“great deal” or “a fair amount.”** Following traumatic events most people are able to turn to lay support networks for help. They concluded that **“given that psychological debriefings in the immediate aftermath of a major incident are at best ineffective and at worst counter-productive such results are reassuring.”**
(See <http://bmj.bmjournals.com/cgi/content/abstract/331/7517/606?>)
- ❖ Up to 75% of people who are confronted with irrevocable loss do not show intense distress.

- ❖ Following almost any imaginable trauma, approximately 50% of those most directly affected report at least one positive life change or benefit that they link as a result of their traumatic experience (Nolen-Hoeksema & Davis, 2004).
- ❖ There is, however, a sizeable minority of adults (approximately 20% - 25%) who will show evidence of long-term, persistent, chronic adjustment problems (e.g., PTSD and related emotional and behavioral difficulties), even to the point of attempting suicide (see Meichenbaum, 2005). Even after treatment, one-third of traumatized clients continue to suffer from PTSD and related problems. If we want to be of help to this latter group of individuals who continue to suffer, then we must ask what differentiates those individuals who demonstrate resilience versus those who manifest chronic, persistent clinical levels of distress.
- ❖ While a number of pre-trauma, trauma-related and posttraumatic factors have been implicated in contributing to chronic, persistent PTSD and related distress, as summarized in **Table 2** and by Abueg and Young (2005) and Dalgleish (2004), the present explanatory focus will be on **Constructive Narrative Perspective** or the “stories” that traumatized individuals offer others, as well as themselves, and on the behaviors that they do and do not engage in (see Meichenbaum, 2006 and **Table 3**).

FACTORS THAT INHIBIT RESILIENCE

STIMULUS CHARACTERISTICS OF THE TRAUMATIC EVENTS

- ❖ **Objective Features** (*severity, duration, proximity, degree of destruction and dislocation – extreme exposure to loss of life and resources*)
- ❖ **Subjective Features** (*accompanying sense of guilt, shame*)
- ❖ **Role of Cognitions and Affect** (*thinking style, “mind set”*)

REACTIONS OR RESPONSE TO THE TRAUMA

(Symptomatic behaviors and level of functioning)

- ❖ **Reactions at the time of the trauma** (*level of arousal, dissociative and avoidant behaviors, especially during or just after the trauma, experience depersonalization, derealization and amnesia during and immediately after trauma – “in a fog”, “not real”*)
- ❖ **Current reactions to the trauma** (*symptomatology*)

Neurobiological changes that result from trauma experiences, especially if exposure was during early childhood and prolonged. (For example, neurobiological changes may include changes to limbic system, hypersensitivity of hypothalamic-pituitary-adrenal (HPA) axis, dysregulation of arousal systems and endogenous opioid system, deficits in the self-regulatory system.)

- ❖ **Presence of comorbidity** (*depression, suicidality, anxiety, substance abuse*)
- ❖ **Subjective meaning (perceived implications) of reactions** (*secondary victimization, “shattered beliefs”*)

DEVELOPMENTAL VULNERABILITY FACTORS

- ❖ **Pretrauma risk experiences** (*prior victimization, intergenerational transmission of victimization experiences, growing up in a harsh, highly critical invalidating environment*). *Previous psychiatric symptoms or disorders and previous unresolved traumatic experiences.*
- ❖ **Presence of other risk factors and absence of protective factors** (*individual, social and systemic factors*)

RECOVERY ENVIRONMENT

- ❖ **Ongoing stressors and barriers** (*resultant stressors*)
- ❖ **Individual, social, community/societal features** (*supports and barriers*)

The combination of these factors can conspire to increase an individual's vulnerability and "rob" resilience. **The present focus will be on the role of cognitions and accompanying affect.**

THE ROLE OF COGNITIVE AND AFFECTIVE FACTORS

A burgeoning literature has now emerged that has highlighted the role that an individual's or group's "thinking style" plays in influencing one's reactions to trauma. If resilience reflects a "positive" mind set, we can consider what is the "mind set" of individuals who develop chronic, persistent PTSD.

It is proposed that a critical feature for developing chronic PTSD and accompanying adjustment problems following exposure to trauma include:

1. Engaging in self-focused cognitions that have a "victim" theme and that undermine ("shatter") core beliefs concerning safety, trust, power/control, esteem and intimacy (McCann & Pearlman, 1990);
2. Supplementing the "victim" theme of one's narrative with a set of specific cognitive behaviors consisting of remaining hypervigilant, ruminating, brooding, engaging in both counterfactual thinking and upward social comparisons, self-blame and blaming others, with the accompanying feelings of guilt, shame and anger which can engender maladaptive feelings, thoughts and behaviors;
3. Viewing the implications of one's reactions to trauma as negative, not only for now but also in the future, while continuing to persistently pine for the past;
4. Searching for "meaning", as evident in continually asking "why" questions, for which there are no satisfactory answers, resulting in the absence of any resolution or closure;
5. Engaging in avoidant and safety behaviors, delaying help-seeking behaviors and failing to share one's trauma experiences with others ("keeping it a secret").

Research indicates that holding such negative, overgeneralized, trauma-related beliefs and cognitions have been associated with increased PTSD severity following traumatic events (Harris & Valentier, 2002; Newman, Riggs & Roth, 1997; Owens & Chard, 2001).

These narrative characteristics that lead to poor adjustment will now be examined. The research that supports these observations is summarized in **Table 3**.

SUMMARY OF WHAT YOU NEED TO DO TO HAVE PERSISTENT PTSD: A CONSTRUCTIVE NARRATIVE PERSPECTIVE

A. ENGAGE IN SELF-FOCUSED COGNITIONS THAT HAVE A “VICTIM” THEME

1. See self as being continually vulnerable
2. See self as being mentally defeated
3. Dwell on negative implications
4. Be preoccupied with others’ views
5. Imagine and ruminate about what might have happened (“Near-Miss” Experience)

B. HOLD BELIEFS

1. Changes are permanent
2. World is unsafe, unpredictable, untrustworthy
3. Hold a negative view of the future
4. Life has lost its meaning

C. BLAME

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

D. ENGAGE IN COMPARISONS

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

E. THINGS TO DO

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

F. WHAT NOT TO DO

1. Fail to believe that anything positive could result from trauma experience
2. Fail to retrieve, nor accept data of positive self-identity
3. Fail to seek social support
4. Experience negative, unsupportive environments (*indifference, criticism, “moving on” statements*)
5. Fail to use faith and religion as a means of coping

A CONSTRUCTIVE NARRATIVE PERSPECTIVE OF PERSISTENT PTSD

*(See Brewin & Holmes, 2003; Ehlers & Clark, 2000; Harvey, 2002;
Meichenbaum, 1997, 2000; Meichenbaum & Fitzpatrick, 1993;
Meichenbaum & Fong, 1993)*

What you need to say to yourself and to others and what you need to do and fail to do in order to develop and maintain persistent PTSD and experience slower recovery.

In order to experience persistent PTSD, traumatized individuals need to:

A. ENGAGE IN SELF-FOCUSED COGNITIONS THAT HAVE A "VICTIM" THEME

1. See oneself (and significant others) as victim(s), permanently changed, at continuing ongoing risk and as being highly vulnerable. (Not see the traumatic event as time-limited.)

"I feel trapped by time - a prisoner of the past"

"I am stuck in the past"

"I can't shake the memory."

"I'm soiled goods."

"My body is ruined."

2. See oneself as being mentally defeated (feeling a loss of psychological autonomy)

"I don't feel human anymore."

"I'm detached - like a spectator watching my life go by."

"I have no control over anything."

"I am in a state of continual confusion."

3. Dwell on the negative implications of reactions (symptoms) resulting from exposure to traumatic events. (See symptoms as signs of emotional and moral weakness.)

"This is not normal. I can't control my reactions. I get gripped by a terrible fear."

"I am just going downhill."

"If I react like that, I am unstable. I'm going mad."

"I am on a psychic tightrope and a psychological wreck."

"I shut down emotionally. I am brain dead."

"It's like I'm a spectator looking in."

"I am half-alive."

"I am powerless."

4. Be preoccupied that others will view them (and significant others) as "victims," "flawed," "permanently damaged."

"Others can see I am a victim."

"Others are ashamed of me now."

"They think I'm too weak to cope on my own."

"I berate myself, before others do."

"I am changed in a fundamental way."

B. HOLD BELIEFS THAT

1. Trauma has brought about a negative and permanent change in the self and reduced the likelihood of achieving life's goals

"I deserve the bad things that happen to me."

"I'll never be able to relate to people again."

"I am undeserving of respect and undesirable to everyone."

"I am too weak (ineffective, unable, helpless) to protect myself (my loved ones)."

"I am a walking target."

2. World is unsafe, unpredictable and individuals are untrustworthy

"Nowhere is safe. The world is an extremely dangerous place."

"I can't trust my own instincts anymore."

"I can't rely on other people."

"All men are alike. You can't trust them."

"I don't let the other kids out of my sight. Nowhere is safe."

3. Reflect a negative view of the future and have low expectations that things will (or can) change or improve (exaggerate the probability of future negative events)

"I am anxious about the future."

"The worst is yet to come."

"There is no hope."

"I'm doomed."

"I'm futureless."

4. Consider that life has lost or has little or no meaning (existential and spiritual despair)

"Life's goals are no longer important."

"Our life now has a dark cloud over it"

"My life is destroyed"

"All of our family occasions will be tainted."

"We will never be happy again,"

"I lost my faith in God. How could He allow this tragedy to happen?"

"I don't care if I live or die. Nothing matters!"

"I am mentally defeated, totally destroyed."

C. ENGAGE IN EXTRAPUNITIVE NARRATIVE PLOTTING

1. Focus on others who are blameworthy with accompanying anger and preoccupation with revenge

"I have been betrayed."

"I will get even, even if it is the last thing I do."

"I won't rest until there is justice."

"My anger is palpable."

2. Focus on blaming oneself with accompanying guilt, shame and humiliation. (Engage in characterological self-blame.) High levels of anger, and more specifically anger towards others, predicts slower recovery from PTSD. In victims of violent crime, shame is a predictor of PTSD.

"I failed to protect her."

"Think of the lowest thing in the world and whatever it is, I am lower."

"I am a gullible person, so weak and stupid."

"I am deserving of this pain. What do you pay when someone dies because of you? You pay with your own life."

"People will wonder what kind of family we are because we allowed this to happen."

D. ENGAGE IN UNFAVORABLE NEGATIVE COMPARISONS

1. Continually compare self to others

"I should be over this by now. Look at her."

"How did she recover without any help, but I need as much help as I can get?"

"I blame myself for not being able to get back to normal!"

2. Ruminate about how life was before the traumatic events versus how things are now. (Note individuals may have rose-colored views of the past.)

"I can't connect with my former self."

"Life will never be the same again,"

"I just keep wishing that life would go back to the way it was last year."

3. Continually pine about how life is now versus how life might have been if the traumatic events had not occurred.

"I will never have grandchildren."

"My child will never know his father."

"The little boys will forget what she was like."

"Where would she be now?"

"Her friends have gone on with their lives."

4. Continually imagine and ruminate about what traumatic event might have occurred - continually reflect on "Near-Miss" Experience and what this portends for the future.

"Do you have any idea how close we were to X?"

"It could have been us."

"I keep wondering what they could have done to us. They are still out there."

"I'll never be safe again."

E. ENGAGE IN COGNITIVE AND BEHAVIORAL TRAUMA-MAINTAINING ACTIVITIES - WHAT TO DO IN ORDER TO MAINTAIN PERSISTENT PTSD

1. Be continually hypervigilant which is readily triggered by reminders and engage in safety behaviors even when unwarranted. Such hypervigilance is maintained and reinforced by the fact that the "reliving" of traumatic memories tend to have a distortion in the sense of time. Such traumatic events seem to be happening in the present, rather than belonging to the past.

"I have to be on the lookout all the time."

"I can't be around anything that reminds me of what happened."

"Those reminders open old wounds."

"My emotional alarm clock goes off when I least expect it to."

"These thoughts haunt me."

"The depression just comes."

2. Engage in deliberate avoidant behaviors at the cognitive level such as suppressing unwanted thoughts, dissociation, and engage in "undoing" behaviors

"I try to push it out of mind, not think about it, but it doesn't work."

"I avoid being with people because I am afraid I will lose control"

"I drink my pain away. It is the only way I can escape."

"Maybe it wasn't rape? He didn't have a weapon and he didn't physically harm me."

"I keep imagining ways I could have defended myself."

3. Engage in avoidant behaviors such as avoidance of trauma reminders, use of alcohol or medication to control anxiety, social withdrawal from others, abandonment of normal activities, and the adoption of safety behaviors that prevent or minimize trauma-related negative outcomes

"I have to stay away from everyone or I will lose control."

"I self-medicate."

"I have to protect myself or I will become overwhelmed."

4. Engage in ruminative behaviors and counterfactual thinking

"Only if... "

"If only... "

"Why me?"

"Why now?"

"If I do X, then Y will happen."

"If I don't do X, then Z will happen."

5. Engage in delaying “change behaviors”

"I will change only when ..."

"Once I get (do) ... I will then begin to ..."

"Once the insurance funds come in I will begin ..."

6. Fail to share and resolve traumatic account. (Fail to self-disclose, and fail to seek social supports.) Rather, keep the traumatic event a "secret", not work through the event, fail to resolve, so the "story" is fragmentary, disjointed, disconnected from the past, poorly elaborated and disorganized. Such traumatic memories are subject to "perceptual priming" - mainly sensory and motoric aspects in which the worst moments stand out. Traumatic memories are poorly elaborated and poorly integrated into existing autobiographical memories. They are dominated by sensory details, namely vivid visual images that may include sounds, smells and other sensations. The trauma memories may also contain gaps, parts may be clear and parts vague. The flashbacks are detailed and emotionally-laden. They are experienced as happening in the present.

"I am as sick as my secrets."

"There is no closure."

"I have difficulty figuring out what happened when ..."

"I feel like I can't let go of the memory."

"There is no beginning, middle, and especially, no end in sight."

7. Put self at continuing risk for revictimization

F. COGNITIVE AND BEHAVIORAL ACTIVITIES- WHAT NOT TO DO IN ORDER TO MAINTAIN PERSISTENT PTSD

1. Do not believe that anything positive will come from this traumatic event, nor that one can become "strengthened" as a result of trauma experience.
2. Fail to retrieve any data of positive self-identity, readily dismiss such "positive" data and not take it as "evidence" to unfreeze beliefs about self, the world, or the future.
3. Fail to seek social supports.
4. Fail to experience a supportive, nurturing environment. Instead, experience a negative social, unsupportive environment of indifference, criticism and "moving on" statements. (This is particularly true for women,)
5. Fail to use one's faith or religion as a means of coping.

TABLE 3
CHARACTERISTICS OF THE NARRATIVE
ASSOCIATED WITH PERSISTENT AND HIGHER LEVELS OF
DISTRESS FOLLOWING TRAUMA EXPOSURE

<u>THINKING PATTERN</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
Engage in Counterfactual Thinking	<p><i>“If only I had ... this would not have happened.”</i></p> <p><i>“Only if ...”</i></p> <p><i>“I never thought this would happen to me.”</i></p>	Davis & Lehman, 1995; Greenberg, 1995
Self-blaming and guilt-engendering thinking (Blameworthy, ashamed, humiliated, full of regrets)	<p><i>“I should have ...”</i></p> <p><i>“I failed to protect her.”</i></p> <p><i>“I berate myself before others do.”</i></p>	Kubany & Manke, 1995; Lee et al., 2001
Focus on blaming others	<p><i>“I have been betrayed.”</i></p> <p><i>“I won’t rest until there is justice.”</i></p>	Janoff-Bulman & Lang-Gunn, 1988
Espouse culturally-based blame attributions	<p><i>“People will wonder what kind of family we are because we allowed this to happen.”</i></p> <p><i>“Because I was raped, people will think that (Black, White) women are loose.”</i></p> <p><i>“They will think I am too weak to cope.”</i></p>	Neville et al., 2004

TABLE 3 CONTINUED
CHARACTERISTICS OF THE NARRATIVE
ASSOCIATED WITH PERSISTENT AND HIGHER LEVELS OF
DISTRESS FOLLOWING TRAUMA EXPOSURE

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
Engage in self-focused thinking (Viewing self as a “victim,” mentally defeated and permanently changed)	<p><i>“I feel trapped.”</i></p> <p><i>“I have no control over anything.”</i></p> <p><i>“I am brain dead.”</i></p> <p><i>“Dead man walking.”</i></p> <p><i>“My body (reputation) is ruined forever.”</i></p>	Ehlers & Clark, 2000
Altered beliefs (World is unsafe, future unpredictable, people are untrustworthy)	<p><i>“No place is safe.”</i></p> <p><i>“I can’t trust my instincts (judgment) any longer.”</i></p> <p><i>“You can’t trust anyone.”</i></p>	Janoff-Bulman, 1999
Be hypervigilant (Perceive ongoing threat and impending doom. Distinctions between “then, there, here and now” are blurred)	<p><i>“I live in fear.”</i></p> <p><i>“I am on every day. Danger is everywhere.”</i></p> <p><i>“I am on the lookout all the time.”</i></p> <p><i>“I am a walking target.”</i></p> <p><i>“I can’t let the kids out of my sight.”</i></p>	Ehlers et al., 2002; Foa et al., 1989

TABLE 3 CONTINUED
CHARACTERISTICS OF THE NARRATIVE
ASSOCIATED WITH PERSISTENT AND HIGHER LEVELS OF
DISTRESS FOLLOWING TRAUMA EXPOSURE

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
<p>Think negatively about the past, present and future. (Fail to retrieve specific “positive” memories.)</p>	<p><i>“It will never be over.”</i></p> <p><i>“My life is destroyed.”</i></p> <p><i>“Time is my enemy.”</i></p>	<p>Hoeksema & Davis, 2002; Treyner et al., 2003</p>
<p>Ruminate and brood about the past and focus on what has been lost. (Continually pine for the past.)</p>	<p><i>“I just wish life would go back to the way it was.”</i></p> <p><i>“I can’t rest until I get even.”</i></p> <p><i>“I’ll never get over it.”</i></p>	<p>Holman & Silver, 1998: Nolen-Hoeksema & Davis, 2003; Wortman & Silver, 1987</p>
<p>Ruminate about “near miss” experiences</p>	<p><i>“It could have been us.”</i></p> <p><i>“You know how close we were to being hurt?”</i></p> <p><i>“It percolates, over and over. There are reminders everywhere.”</i></p> <p><i>“My thoughts are like an overcrowded train that jump from track to track.”</i></p>	<p>Meichenbaum, 1997</p>
<p>Dwell on negative implications of reactions</p>	<p><i>“If I react like that, it must mean that I am going mad.”</i></p> <p><i>“This is not normal. I can’t control my emotions and this means ...”</i></p>	<p>Ehlers et al., 2002</p>

**TABLE 3 CONTINUED
CHARACTERISTICS OF THE NARRATIVE
ASSOCIATED WITH PERSISTENT AND HIGHER LEVELS OF
DISTRESS FOLLOWING TRAUMA EXPOSURE**

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
<p>Engage in deliberate avoidant and safety behaviors, even if unwarranted. (Cognitive and behavioral avoidance that leads to being “stuck,” disengaging and giving up.)</p>	<p><i>“I can’t allow myself to think about it.”</i></p> <p><i>“I delay seeking help.”</i></p> <p><i>“I am not worthy of help.”</i></p> <p><i>“I can’t share this with anyone. No one would understand.”</i></p> <p><i>“I can’t allow myself to have a good time.”</i></p> <p><i>“If I deprive myself, then ...”</i></p> <p><i>“I try and keep busy so I don’t think about this.”</i></p>	<p>Ehlers & Clark, 2000; Ehlers & Steil, 1995</p>
<p>Feel helpless, hopeless, demoralized, and victimized by one’s thoughts, feelings, circumstances</p>	<p><i>“These thoughts just keep coming.”</i></p> <p><i>“I get griped by my feelings of depression and fear.”</i></p> <p><i>“I don’t think I can stand the pain anymore.”</i></p>	<p>Meichenbaum, 1997</p>

TABLE 3 CONTINUED
CHARACTERISTICS OF THE NARRATIVE
ASSOCIATED WITH PERSISTENT AND HIGHER LEVELS OF
DISTRESS FOLLOWING TRAUMA EXPOSURE

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
Engage in upward social comparison	<p><i>“How come she is doing so well and she went through less?”</i></p> <p><i>“Others will see that I am a victim.”</i></p> <p><i>“Why do I have to have problems other people don’t have?”</i></p>	McAdams et al., 2001
Continually and extensively search for meaning, but fail to find satisfactory resolution	<p><i>“What did I do to deserve this?”</i></p> <p><i>“Why me?”</i></p> <p><i>“Why now?”</i></p> <p><i>“I lost faith in God.”</i></p>	Silver et al., 1983; Tait & Silver, 1989

In contrast, consider the kinds of thinking and behaviors that lead survivors toward resilience and growth, as summarized in **Table 4**.

CHARACTERISTICS OF RESILIENT ADULTS

What Resilient Individuals Do

- ❖ Realistically optimistic about life – hold beliefs that things can change for the better and hold the accompanying beliefs that they have the ability to help bring about such change
- ❖ Engage in goal-setting that is personally valued (Hold a “Goal, Plan, Do, Check” approach) and show evidence of the ability to follow-through
- ❖ Demonstrate a sense of self-efficacy and sense of personal control. Self-efficacy conveys that they can bring about change in those aspects of the situations that are changeable, accept that which is not changeable and know the difference between the two. Hold the view that stressful events can be seen as “problems-to-be-solved” and they have the confidence to take actions and monitor the results of their efforts.
- ❖ Look at the bright side – be appreciative of what they have and acknowledge what they did to survive and what they have accomplished in spite of exposure to stressful events
- ❖ Use their faith and cultural history to bolster their self-confidence (***SEE BELOW FOR A DISCUSSION OF THE ROLE THAT FAITH-BASED PRACTICES AND SPIRITUALITY PLAY IN FOSTERING RESILIENCE***)
- ❖ Find meaning and purpose in life
- ❖ Make a “gift” of their survival to others

What Resilient Individuals Do Not Do

- ❖ Don't engage in social comparisons and self-blaming
- ❖ Don't engage in “thinking traps”
- ❖ Don't view failure as end-points
- ❖ Don't engage in “negative thinking” - if they have occasional negative thoughts they are able to balance such thoughts with “positive hopeful thoughts.” (Ratio of approximately 4:1, positive to negative thoughts)

EMOTION REGULATION

What Resilient Individuals Do

- ❖ Demonstrate emotional regulation
- ❖ Stay calm even when under pressure – not fazed by problems
- ❖ Use acceptance and tolerance strategies – be “mindful” of present

What Resilient Individuals Do Not Do

- ❖ Don't use avoidant coping strategies or engage in self-protective and delay-seeking actions that can make the situation worse (e.g., abuse substances to control negative affect; engage in high-risk behaviors to control negative affect such as sensation seeking behaviors that can contribute to revictimization)

BEHAVIORAL ACTS

What Resilience Individuals Do

- ❖ Take actions designed to address stressful events
- ❖ Depending on the demands of the situation, they may use direct-action, task-oriented coping strategies. In other situations when not doing something is the best approach, they use emotionally palliative coping techniques. Resilient individuals have a flexible repertoire.
- ❖ Take incremental, purposeful actions – strive to achieve important personal goals. These actions have to be implemented in a culturally sensitive fashion and in a way that is commensurate with the group's belief system (*See the information which follows on how to use spirituality and religion to cope with trauma.*)
- ❖ Willingness to seek help and willingness to join with others (e.g., share accounts with trusted others, memorialize, grieve, pray)
- ❖ Help others -- engage in kindness activities

What Resilient Individuals Do Not Do

- ❖ Don't engage in avoidant coping actions
- ❖ Don't remain isolated
- ❖ Don't reject help

The following **Table 4** provides specific examples of the kinds of thoughts, feelings and behaviors that **RESILIENT INDIVIDUALS** engage in. This list is not exhaustive, but is illustrative of what the research literature indicates characterizes resilient individuals.

TABLE 4
KINDS OF THINKING AND BEHAVIORS THAT LEAD
SURVIVORS TOWARD “GROWTH”

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
Benefit seeking, finding and reminding - SELF	<p><i>“No one deserves to experience what happened to me, but I now know I can get through this. I am a stronger person now.”</i></p> <p><i>“I am wiser (stronger) as a result of this experience.”</i></p> <p><i>“I feel like a better person having looked at these awful feelings and knowing that I can survive this too.”</i></p> <p><i>“I am better prepared for whatever comes along.”</i></p> <p><i>“I am less afraid of change.”</i></p> <p><i>“I never know I could get along on my own.”</i></p> <p><i>“I now savor daily pleasures.”</i></p> <p><i>“I am better now at helping others.”</i></p>	Afleck & Tenner, 1996; Linley & Joseph, 2002, 2004
Benefit seeking, finding and reminding - OTHERS	<p><i>“This brought us all together.”</i></p> <p><i>“I learned I am my brother’s keeper.”</i></p> <p><i>“I learned not to immerse myself in other people’s pain.”</i></p> <p><i>“I think about others and how it could have been worse.”</i></p>	McMillen, 2004; McMillen et al., 1995

TABLE 4 CONTINUED
KINDS OF THINKING AND BEHAVIORS THAT LEAD
SURVIVORS TOWARD “GROWTH”

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
Engage in downward comparison	<i>“I recognize that I need to accept help.”</i>	Nolen-Hoeksema & Larson, 1999; Monk et al., 1997
Establish a future orientation	<p><i>“My view of what is important in life has changed.”</i></p> <p><i>“I see new possibilities and goals to work on.”</i></p> <p><i>“I discovered I can use my strengths in new ways.”</i></p> <p><i>“I am now able to focus on the fact that it happened and <u>not</u> on how it happened.”</i></p> <p><i>“My view of what is important in life has changed.”</i></p> <p><i>“I see new possibilities and goals to work on.”</i></p> <p><i>“I discovered I can use my strengths in new ways.”</i></p>	Pals & McAdams, 2004; Tedeschi & Calhoun, 2004

TABLE 4 CONTINUED
KINDS OF THINKING AND BEHAVIORS THAT LEAD
SURVIVORS TOWARD “GROWTH”

<u>THINKING PATTERNS</u>	<u>PROTOTYPIC EXAMPLES</u>	<u>ILLUSTRATIVE RESEARCH</u>
Constructing meaning	<p data-bbox="573 468 1044 541"><i>“We survived. We have a chance to live and we’re choosing life.”</i></p> <p data-bbox="573 579 979 653"><i>“I am no longer willing to be defined by my victimization.”</i></p> <p data-bbox="573 690 1052 905"><i>“I survived for a purpose. I accept that responsibility. I owe it to those who perished to tell their stories (honor their memory, share with others, prevent this from happening again).”</i></p> <p data-bbox="573 942 1027 1052"><i>“Given what I have experienced, I now devote myself to meaningful goals.”</i></p> <p data-bbox="573 1089 1011 1199"><i>“I moved from being a victim to becoming a survivor and even a thriver.”</i></p> <p data-bbox="573 1236 1019 1310"><i>“I can make a gift of my pain and loss to others.”</i></p> <p data-bbox="573 1348 1039 1528"><i>“My mother gave me the gift of her religion and I feel like I learned how not only to be compassionate with others, but how to be compassionate with myself.</i></p> <p data-bbox="573 1566 829 1598"><i>“I now know God.”</i></p>	<p data-bbox="1182 468 1482 499">Abueg & Young, 2005;</p> <p data-bbox="1182 506 1433 537">Frazier et al., 2001;</p> <p data-bbox="1182 543 1401 575">Neimeyer, 2001;</p> <p data-bbox="1182 581 1482 613">Pargament et al., 2000;</p> <p data-bbox="1182 619 1417 651">Silver et al., 1983;</p> <p data-bbox="1182 657 1442 688">Tait & Silver, 1987;</p> <p data-bbox="1182 695 1458 726">Wortman et al., 1997</p>

TREATMENT IMPLICATIONS OF A CONSTRUCTIVE NARRATIVE PERSPECTIVE RESILIENCE

1. **Develop a supportive, empowering therapeutic alliance.**
2. **Conduct assessment interview and use related measures.**
3. **Provide rationale for treatment plan.**
4. **Ensure patient's safety and address disturbing symptoms.**
5. **Educate patients and significant others.**
6. **Teach specific coping skills and build-in generalization-enhancing procedures.**
7. **Help patients change beliefs about implications of experiencing PTSD and associated symptoms.**
8. **Reconsider anything positive that resulted from the experience.**
9. **Address issues of guilt, shame, humiliation, anger.**
10. **"Uncouple" traumatic memories from disabling affect.**
11. **Help patients put what happened into words (or some other form of expression).**
12. **Process and transform emotional pain – make a "gift" of their experience to others.**
13. **Help patients distinguish "then and there" from "here and now." Help them to learn not to overgeneralize.**
14. **Help patients retell their stories and share the "rest of their stories". Retrieve "positive identities" (Use imaginal reliving procedures).**
15. **Help patients "spot triggers" and reduce unhelpful avoidant safety behaviors.**
16. **Have patients engage in graduated "in vivo" behavioral experiments.**
17. **Help patients reclaim their lives and former selves.**
18. **Ensure that patients take credit for changes – self-attributional efforts and self-mastery.**
19. **Help patients avoid revictimization.**
20. **Build in relapse prevention procedures.**
21. **Put patients in a "consultative" role where they describe and discuss what they learned and what they can teach others.**

IMPLICATIONS FOR TREATMENT FROM A CONSTRUCTIVE NARRATIVE PERSPECTIVE

(See Brewin & Holmes, 2003; Ehlers & Clark, 2000; Harvey et al., 2002; Meichenbaum, 1997, 2000; Meichenbaum & Fitzpatrick, 1993; Meichenbaum & Fong, 1993)

“The therapist is an instructor in the art of the narrative.”

“The core of recovery is the narrative construal on which coping rests.”

1. The therapist needs to create and maintain a supportive, compassionate, caring, genuine, empathic, nonjudgmental, empowering therapeutic alliance so that patients feel both safe and comfortable to share the details and impact of their exposure to traumatic experiences. The therapist needs to provide a setting in which the patients can practice telling and retelling their stories with its full intensity at their own pace. The therapist needs to continually monitor the quality of the alliance over the course of therapy.

2. The therapist needs to conduct an assessment interview in order to determine the nature of the patients’ memories for traumatic events and their appraisal processes of their feelings, actions, symptoms and the accompanying implications.
 - (i) *Are the patients’ memories muddled and confused, fragmentary and disjointed, with memory gaps?*
 - (ii) *Do the patients’ memories of traumatic events have a “here and now” quality primed with sensory and motoric features that are distressing?*
 - (iii) *What are the patient’s beliefs and expectations (implications) of experiencing their distressing symptoms and their aftermath?*
 - (iv) *What are the patients’ coping efforts? Are they inadvertently making the situation worse and contributing to persistent PTSD?*

The following clinical questions derived from the clinical suggestions of Ehlers and Clark, 2000; Ehlers et al., 2002; Hackman et al., 2004; Joseph et al., 1997 and Meichenbaum, 1997 illustrate ways to tap an individual’s trauma-related beliefs and cognitions.

You have told me that memories of the (trauma) pop into your mind when you do not want them to. Could you tell me what these memories are like?

Of these different traumatic incidents that you have experienced, which memory troubles you the most?

Could you tell me a bit more about how you experience this memory?

What is it like?

*Is it more like a thought (please describe)? Like a feeling (please describe)?
Or like a sensory experience (please describe)?*

How often did you have these thoughts in the last week?

How clear in your mind (vivid) were these thoughts?

*To what extent did these thoughts and feelings seem to be happening now,
instead of being something from the past?*

Do your memories appear to happen in the “here and now?”

Do the intrusive thoughts you experience include memories from previous events in your life?

How much distress was associated with the experience of these thoughts and feelings?

Please describe the worst moment (“hot spots”) during the trauma.

I have some questions about the intrusive thoughts that you experience most often. Are these intrusions about something that happened before, or during, or after the worst moment?

Have any new intrusions occurred in the last week?

What events seem to trigger your intrusive thoughts?

Have your intrusive thoughts changed in any way over time? (Please describe.)

Do you feel you can control or influence these memories?

Note: These questions can be asked as open-ended questions or patients can be asked to rate their answers on a 0 – 100 scale (0= not at all, and 100 = very much)

In addition to an interview, clinicians can also incorporate other assessment tools to tap patients' negative appraisals. Also, address any myths concerning the trauma experience (e.g., about rape, child sexual abuse). Incorporate corrective information into traumatic memories.

3. The therapist needs to provide patients with a rationale for the treatment and solicit patients' feedback. For example, the therapist can use metaphors – disorganized cupboard or puzzle that needs rearranging, a wound that needs care, and so forth – to convey the need to reorganize and reframe traumatic memories.
4. The therapist needs to ensure that patients are safe from the risk of further victimization and that any immediate disturbing symptoms (e.g., hyperarousal, nightmares, dissociative and suicidal behaviors) are addressed.
5. The therapist needs to educate patients (and significant others) about the nature and impact of trauma and about the reactions (symptoms) that are the hallmark of the condition. Help patients better understand the distinctive characteristics of traumatic memories and the role of “triggers.” Help patients reframe PTSD symptoms and accompanying comorbid sequelae as both the “wisdom of the body,” “survival behaviors,” and as “coping efforts.”
6. Teach specific coping skills to deal with hyperarousal, intrusive ideation, dissociative behaviors, avoidance behaviors, etc. The therapist needs to follow generalization guidelines when teaching such coping skills as acceptance and tolerance, self-regulation, problem-solving and the like (see Meichenbaum, 2001).
7. The therapist needs to help patients change their problematic beliefs about the implications of experiencing PTSD and associated symptoms. Help validate and normalize the patients' reactions and help them accept, tolerate and cope with intense emotions. Use situational and developmental analyses to help patients better appreciate their adaptive efforts and their survival attempts. Collaborate with patients to examine the “impact,” “toll,” and “emotional price” of using these specific forms of coping. Ask what adaptive ways of coping could be used. Engage patients in self-monitoring activities in order to increase early awareness of triggers and distressing symptoms in order to reduce the negative influence on daily activities.
8. The therapist needs to help patients reconsider whether anything “positive” could have resulted from the trauma experience, to reflect on what they have done to “cope.” Highlight data of “strengths” and “resilience,” or what they have been able to accomplish “in spite of” the trauma. Work with patients so they accept such data as “evidence” to unfreeze their beliefs about themselves, the world and the future.
9. The therapist needs to help patients alter their sense of responsibility, guilt, shame and humiliation that may accompany victimization experience. There is a need to attend to feelings and beliefs maintaining shame, guilt and anger, in addition to fear and anxiety (See Kubany & Manke, 1995; Smucker et al., 2002).
10. Help patients “uncouple” traumatic memories from disabling affect and maladaptive behaviors. Educate patients on how their current behaviors (such as

ruminations, self-hatred, self-berating, avoidance, thought suppression, use of substances, persistent anger) inadvertently make the situation worse. Help patients learn ways to break the “vicious cycle” of appraisals, feelings, thoughts, behaviors and resultant consequences.

Use clock metaphor where **12 o'clock** represents internal and external triggers; **3 o'clock** represents primary and secondary emotions; **6 o'clock** represents automatic thoughts, “hot cognitions,” thinking style, and schemas or personal issues and **9 o'clock** represent behavioral acts and resultant consequences. The therapist should help the patients see the interconnections between each of these components. In this way, patients can better understand how they unwittingly, inadvertently and perhaps even unknowingly contribute to their persistent distress.

11. The therapist needs to help patients put into words, in a culturally sensitive fashion, what happened. A number of therapeutic procedures have been developed to achieve this goal including cognitive rescripting procedures (Resick & Schnicke, 1993); direct therapy exposure (Foa & Rothbaum, 1998); imagery rescripting (Smucker and Niederee, 1995). By doing so, patients can contextualize their memories, develop useful insights, identify and discuss “hot spots.” They can begin to develop a sense of control and learn that they can survive, not fall apart, nor “go crazy,” in the retelling of the trauma experience.
12. The therapist needs to help patients organize, elaborate, integrate and process their traumatic memories into a coherent narrative that fosters a sense of meaning and nurtures hope. Help patients fit their “trauma narratives” into their broader life histories so the traumatic events become part of their general life perspective, namely “a slice of life” and not the whole story. Help patients come to terms with the losses and transform their emotional pain into something positive that can come from their experiences. Help patients find meaning, make a “gift” of their experiences, and use “spiritual” and religious practices, if congruent with their beliefs.
13. The therapist needs to help patients change their beliefs about current and ongoing threats, learning to discriminate between “then and there” and “here and now.” Help the patient learn how not to overgeneralize the degree of ongoing threat and danger. Help the patients view trauma as a discrete time-limited.
14. The therapist needs to help patients retell their stories by means of imaginal reliving, including their thoughts, feelings, behaviors, reactions of others. Help patients to consider any accompanying problematic beliefs (see Smucker et al., 2003). Have patients consider how the traumatic events challenged their cherished beliefs of invulnerability, of a just and trusting world and a sense of self-worth. Where indicated, address the patients’ feelings of abandonment, estrangement, inadequacy and despair. Ask about the “rest of the story” of survival skills and strengths. Help patients retrieve and accept “positive identities.”

15. The therapist needs to help patients spot “triggers” (both internal and external), develop more adaptive coping behaviors and come to recognize that their so-called “safety” avoidant behaviors may inadvertently contribute to persistent PTSD. Assist patients in reducing unhelpful behavioral and cognitive strategies (e.g., use of substances to escape emotional pain; avoidant behaviors to control rage).
16. The therapist needs to help patients engage in in vivo exposure and personal behavioral experiments in a graduated fashion in order to test out their beliefs. Help patients emotionally accept that the traumatic event is in the past. Help patients examine their “What if . . . thinking should possible events occur?” and “What is the worst thing that could happen?” The therapist helps patients put these thoughts in the form of predictions that are testable and learn how to use other cognitive restructuring procedures. Ensure that the patients have coping skills, plans and backup plans to undertake personal experiments (often with the initial assistance of others).
17. The therapist needs to help patients “reclaim” their lives and former selves. Help patients connect with strengths, utilize social supports, help others and reintegrate into their communities. The therapist should foster a “sense of possibilities” and the therapist can use the “language of becoming” that further nurtures hope.
18. The therapist needs to ensure that patients “take credit” for changes that they have achieved. The therapist needs to ask “what” and “how” questions and help patients develop a sense of personal efficacy, agency and enhance feelings of self-mastery.
19. The therapist needs to ensure that patients have skills to avoid revictimization experiences. Consider lessons learned and develop behavioral and interpersonal strategies to control perceived threats and reduce the risk of revictimization.
20. The therapist needs to build relapse prevention procedures into the treatment regimen (e.g., ways to anticipate and cope with possible lapses and anniversary effects).
21. The therapist needs to put the patients in a “consultative role” so they have an opportunity to describe and discuss what they have learned and how they specifically plan to implement what they have learned, even in the face of potential barriers and obstacles. Help patients get to the point where they could now teach others what they have learned. Revisit the collaboratively generated therapeutic goal statements and examine how patients have been able to achieve these goals and determine what is the “unfinished business” (e.g., use a personal journey metaphor).

WHAT CAN BE DONE TO FOSTER RESILIENCE IN ADULTS IN THE IMMEDIATE AFTERMATH OF A TRAUMATIC EXPERIENCE?

(See Abueg & Young, 2005; Brewin et al., 2000; Bryant et al., 1999; Hayes, 2002; Litz, 2004; Meichenbaum, 1997; Young et al., 1999)

I. Provide psychological first aid

- a) Within two weeks of impact in the acute phase of a disaster help victims meet basic needs for safety, relocation, reunification with loved ones, food, water and health care
- b) provide comfort, validate, reassure, normalize and educate in tolerable doses about possible outcomes, the expected course and ways to manage symptoms to avoid putting themselves at higher risk like extensively watching television coverage of the disaster
- c) nurture a sense of self-efficacy and control
- d) reframe long suffering and coping techniques as “signs of resilience”
- e) refer high-risk individuals to supplemental assessment and treatment

II. Help traumatically-exposed individuals to use **relaxation-based interventions** such as controlled breathing techniques, acceptance mindfulness strategies (*“Take it slow;” “Not pressure self;” “Respect natural pace of healing;” “Follow the wisdom of the body.”*)

III. Help individuals **access and use social support groups** to share accounts of what happened and what the individuals did to survive. Share “unspoken” memories with supportive others, Help individuals grieve and memorialize. Help them engage in **social problem solving** and **find meaning**.

IV. Use **direct therapeutic exposure procedures** to help combat avoidance/safety behaviors that inadvertently help to maintain distress and PTSD. Build in relapse prevention procedures.

ADDENDA

As noted, one of the major ways victimized individuals cope with the aftermath of trauma is to turn toward some form of spirituality or religious beliefs and practices. Because of the importance of religious forms of coping as a way of nurturing resilience, a separate Section of **Trauma, Spirituality and Recovery** is included.

Resilience is critical for those individuals who work with victims of traumas. In order to reduce the impact of vicarious traumatization and as a way to bolster resilience. A Section has been prepared entitled **Ways to Bolster Resilience in Helpers**.

Please see the two Addenda:

1. **Trauma, spirituality and recovery**
2. **Bolstering resilience in helpers; Using individual, social and organizational interventions to address vicarious traumatization and job stress**

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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://alted-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/>

Examples of Websites devoted to Positive Psychology and to the development of strengths and resilience in children and adults
<http://www.positivepsychology.org/>
<http://www.reflectivelearning.com/>
<http://www.authentichappiness.org/>
<http://www.apa.org/apags/profdev/pospsyc.html>

Association of State Mental Health Program Directors
<http://www.nasmhpd.org/>

Summaries of prevention and health
<http://www.oslc.org/spr/apa/summaries.html>

Summaries of best-practices evidence-based interventions with children
<http://www.effectivechildtherapy.com/>

Summary of prevention programs

<http://preventionpathways.samhsa.gov/programs.htm>

National Registry of Effective Programs and Practices

http://modelprograms.samhsa.gov/template_cf.cfm?page=model_list

ADDENDUM I TRAUMA, SPIRITUALITY AND RECOVERY

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THE ROLE OF SPIRITUALITY IN THE HEALING PROCESSES

“Among the New Orleans evacuees in the Houston shelters, 92% of those surveyed say that religion played an important role in helping them get through the past two weeks.”

(See <http://www.kff.org/newsmedia/7401/cfm>)

One way that individuals cope with traumatic stress is by using religion, prayer and some form of spirituality. This **Section** discusses:

- (1) evidence for the importance of an individual’s faith in contributing to resilience;**
- (2) how to use interview and self-report measures to assess how faith-based coping strategies and procedures are utilized;**
- (3) various ways individuals, families, and communities can use spirituality-based coping strategies;**
- (4) ways that clinicians (helpers) can collaboratively incorporate spirituality-based interventions into their therapy practices in a culturally sensitive fashion.**

As a Gallup poll indicated, American are a very spiritual group. Thoresen and Plante (2005, p. 1) report that:

“Over 96% of Americans believe in God or a higher power, 60% belong to a local religious group, 60% think that religious matters are important or very important and 40% attend religious services almost weekly or more, and 80% are interested in ‘growing spiritually.’”

However, not all people who report being spiritual consider themselves religious. Not all people 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. Religion refers to a form of social institution with its accompanying beliefs, practices, symbols and rituals.

The **importance of spirituality**¹ and **religion** in the healing process from trauma is highlighted by Cacioppo and colleagues (2005) who observe that sociality, spirituality and meaning-making are central features of human beings. They convincingly summarize the research that both **relational connectedness** and **collective-connectedness** combat feelings of isolation and loneliness. These are also critical to the

¹ 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”, conveying a similar meaning). Thus, spirituality can give breath and hope to individuals.

healing processes. One form of connectedness that is important to many victimized individuals is the formation of a personal relationship with a deity or a higher power.

It is critical, however, that helpers do not impose their religious beliefs on victimized individuals, but rather that they naturally tap the survivors' faith as a coping tool.

Why is it important to consider some form of religious or spiritual behavior when working with traumatized individuals?

As Bergin (1983), Gartner et al. (1991) and Meichenbaum (1997) observe, the major way that people in North America cope with traumatic events is by means of **faith and prayer**.

For example, after the events of the terrorist attack on September 11, 2001, 90% of Americans reported that they turned to prayer, religious or spiritual activity with loved ones in an effort to cope. Research also indicates that some 43% - 60% of people, who have emotional problems, turn first to their clergy for help. Spirituality has been found to be positively correlated with physical and emotional well-being. Gall et al. (2005) have highlighted that religious coping has a significant association with a variety of adjustment factors including lower depression, greater happiness and life satisfaction, greater use of social supports, optimism, better self-related health, fewer somatic complaints, lower alcohol consumption, fewer interpersonal problems and overall general coping, and lower mortality.

Such religious activities and a relationship with a transcendent power (God) play an important role in the coping process, especially if God is perceived to be nurturing, loving, comforting, protective and available.

Many people turn toward their faith under extreme, stressful conditions such as trauma or severe illness. As Gall et al. (2005, p. 95-96) observe,

“If a higher power is perceived to be at work in a stressful event, 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.”

It should be noted, however, that under certain conditions, religion can have negative effects, if the belief system interferes with medical health-seeking behaviors when indicated or if the form of religion reinforces stereotypes and contributes to intolerance. Gall et al (2005) also highlight that certain forms of “spiritual struggles” can contribute to higher levels of distress. For instance, when God is viewed as punitive, vengeful, withholding, and when individuals use prayer as a form of pleading and engage in avoidant and delay-seeking behaviors awaiting God's interceding, then distress can increase. The attribution of stressful events to “the devil” or some form of demonization has also been found to correlate with higher levels of distress. A collaborative and self-

directing prayerful stance has been found to be a more adaptive form of coping (Dyson et al., 1997; Emmons, 1999; Koenig et al., 2001; Millar, 1999; Miller & Marten, 1988).

How does spirituality and related religious activities help with the healing process?

While we do not know the exact mechanisms by which spirituality operates, engaging in such shared group religious activities may mitigate a sense of isolation and loneliness while foster a sense of connectedness. Socially connected individuals are more likely to meet the demands of everyday stressors by means of active coping and by recruiting help from others. In contrast, individuals who feel socially isolated are likely to:

“Construe their world (including the behavior of others) as threatening and punitive. They are more likely to appraise stressors as threats, rather than as challenges and to cope with stressors in a passive fashion by isolating themselves from others and by withdrawing from the problem situation.” (Cacioppo et al., 2005, p. 1590).

Socially connected individuals are more likely to behave in a selfless way, reinforcing their connections to others and enhancing their self-esteem. Socially isolated individuals are more likely to act in a socially protective and self-defeating manner.

Cacioppo et al. also observe that such social isolation and accompanying loneliness can have negative physiological consequences (increased sympathetic activation and sleep disturbance) that can exacerbate stressful reactions.

It has also been proposed that engaging in religious behaviors can prove helpful for handling those aspects of stressful situations that cannot be personally controlled or changed and that are not amenable to direct-action problem-solving coping efforts. As an example, the following possible mediating effects that may occur after engaging in religious behaviors:

- (1) Accessing the social, emotional and material supports of fellow religious participants and clergy;
- (2) Engaging in religious activities such as prayer, meditation, drumming, chanting, Bible reading can prove emotionally comforting. (In fact, the Bible can be used as a form of inspirational self-help book);
- (3) Placing faith and trust in a “just and loving God” may provide traumatized individuals with a “supportive partner” and “confidant;”
- (4) Providing an explanatory frame of reference (meaning-making) and a source of help;
- (5) Providing a sense of relief, comfort, security and belonging;
- (6) Helping preserve a belief in a just world;

- (7) Nurturing hope and optimism that leads to engaging in goal-directed behavior and visions (Snyder, 2000);
- (8) Encouraging the access of inner strengths, acceptance, empowerment and control;
- (9) Providing ways to deal with specific fears (death).

How can helpers (therapists) determine the role spirituality plays in an individual's, family's and community's coping repertoire?

Helpers can ask a series of open-ended questions. They may also use various self-report scales to probe about the role spiritual activities play. Consider the following illustrative questions:

How important is religion in your life?

How often do you attend religious services and engage in religious activities (prayer, Bible reading, etc.)?

How do you (and your family) go about coping with stress?

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?

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?

Clinicians can also use a series of self-report measures to more systematically assess the individual's use of religious behaviors.

ASSESSMENT

ILLUSTRATIVE MEASURES OF RELIGIOUS BEHAVIORS

Religious Coping Index	Koenig et al., 1992
RCOPE	Pargament et al., 2000
Spiritual Well-being Scale	Ellison, 1983
Religious Problem-Solving Scale	Pargament et al, 1988
God Locus of Health Control Scale	Wallston et al., 1999

Pargament and colleagues (1990) and Gall and colleagues (2005) have provided examples of the variety of religious coping activities that individuals engage in. The coping activities include:

- a) Spirituality-based activities (Use prayer and worship, participate in formal religions rituals, read and study scriptures.)
- b) Feeling strengthened (Have trust and hope in a higher power, say Grace – thank God for surviving and for what one has left, believe you survived for a purpose.)
- 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 (Doing good deeds, helping others, volunteer activities, making contributions to faith communities and to helping agencies, meditating, using spiritual-guided imagery, fasting, drumming, chanting, going on spiritual retreats, connecting with nature and all living things – enjoying nature, gardening, leading a “good life.”)
- e) Seeking religious support (Attending religious services and ceremonies; Watching 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 the past groups). View traumatic events as a way of bringing individuals together.
- f) Constructing meaning (Seek significance out of suffering – a kind of “wake-up” call. Make benign attributions and find remaining benefits. 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.”)

- g) Pleading.
- h) Engaging in avoidant coping efforts.
- i) 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. The following list provides examples of each of these forms of religious coping activities.

Examples of Religious Coping Activities

(See Gall et al., 2005; Pargament et al., 1990; Worthington, 1998)

Note that various religious groups cope differently.

Spiritually-based

- **Believe in a just and benevolent God. Look to God for emotional strength. Trust that God would not let anything terrible happen to me. I trusted the Lord to help me.**
- **Realized that I didn’t have to suffer since Jesus suffered for me.**
- **Used Christ as an example of how I should live.**
- **Took control over what I could and gave the rest up to God.**
- **My faith showed me different ways to handle the problem.**
- **Accepted that the situation was not in my hands, but in the hands of God.**
- **Experienced God’s love and care.**
- **God is greater than evil and God can use this for His good purposes.**
- **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 look forward to life in the future – life will be better.**

Feel Strengthened

- **This is God's way of testing me (us).**
- **I feel strengthened.**
- **Used my signature strengths in a new way.**
- **Feel purified by fire.**
- **This is God's way of teaching us about the preciousness of life.**

Call Upon Forgiveness

- **Jesus died so that I might have forgiveness.**
- **If God forgives us and can cast away our sins, why couldn't I just forgive and forget?**

Perform Good Deeds

- **Tried to be less sinful.**
- **Led a more loving life.**
- **Attended religious services or participated in religious rituals and church groups.**
- **Provided help to others.**
- **Showed my gratitude to others in my life.**

Religious Support

- **Received support from clergy and/or from other members of the congregation.**
- **I played my religious music and it lifted my spirits.**
- **I sing in the church choir.**

Plead

- **Asked for a miracle. Requested divine intervention.**
- **Bargained with God to make things better.**
- **Asked God why it happened.**

Engage in Avoidant Coping Efforts

- **Tried not to think about it.**
- **Kept my feelings to myself.**
- **Avoided being with other people.**
- **Prayed (or wished) for a solution. Prayed that the problem would just go away. Wished for a miracle.**
- **Focused on the world to come rather than 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, controlling and at times punitive.**

How can therapists (helpers) incorporate spiritual, faith-based activities into their treatment?

The following list provides some illustrative examples (See Miller, 1999; Richards and Bergin, 1997 and Plante and Sherman, 2001 for other examples). No matter which form of spiritual activities are to be included, there is a need to do so in a sensitive, respectful, collaborative fashion, soliciting the client's feedback throughout. The helper needs to follow the lead of those who are to be helped.

- Systematically assess for the client's religious beliefs and activities and determine how faith has been used as a coping activity (See Pargament et al., 1988).
- Refer to scripture or use religious metaphors as teaching examples (See Meichenbaum, 1994 for a comparison of Job versus King David).
- Pray with my client in the session.
- Pray for my client.
- Use religiously-based visualization activities (See Propst, 1987).
- Use religious rituals as part of therapy.
- Encourage my client to engage in religious activities of prayer, services, meditation, Bible reading, rituals, confession, repentance, sitting Shiva, engage in candle light vigils, play religious music.
- Encourage the client to engage in forgiveness activities (e.g., see Worthington's 1998 Pyramid Model). For example, Johnson (2001) has offered the following examples of ways to help their clients consider the possibility of forgiveness to themselves and to others.

“Yes, your religion teaches us ..., but correct me if I am wrong, it also teaches us ...”

“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?”

“According to your religion, wouldn't you say that you are a person who ..., but who is still invited to be forgiven?”

“If 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 ...?”

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.

- Provide the client with religious materials to read or use religious bibliotherapy or guide the client to religiously-based Websites (e.g., Frankl 1963; Kushner, 1981).
- Encourage clients to participate in religiously-based treatments such as Alcoholics Anonymous.
- Talk to the client’s pastor, priest, rabbi. Invite clergy to be a co-therapist (e.g., see McMinn et al., 1998).
- Therapists can convey their own “spirituality” to their clients. Comment on resilience of humanity, courage of the human spirit. Use a journey metaphor, language of becoming, joy in participating in the healing of others, and personal growth of the clients.
- Use client's faith as a way to come to a resolution, come to terms with events and their implications, search for a meaningful perspective.

How can therapists use metaphors, analogies and story telling as a way to help victimized individuals become “unstuck” and reframe events?

In the Clinical Handbook of Treating Adults with Post Traumatic Stress Disorder, Meichenbaum (1994) reviews a number of examples of how therapists can use metaphors and stories to help individuals reframe the nature and impact of traumatic events. Expert therapists (helpers) are good “story tellers,” and they choose their analogies in a timely and judicious fashion and in a manner that is personally-relevant to the individual being helped. If possible, the helper can use the helpee’s own experience to select the relevant metaphorical example that nurtures hope and helps individuals get “unstuck” from the negative impact of having been victimized. Consider the following examples that therapists can use with clients.

Possible Additional Metaphors

- a) “One of the rewards of being a therapist is being able to bear witness. I like to think of myself 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 individual'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 he/she might have recorded in his/her therapy notes that document his or her resilience and courage. The therapist can comment on being impressed and inspired by the client’s struggles, determination, and successes, he/she has been able to achieve “in spite of”
- b) Compare someone who has experienced a traumatic event(s) as being like someone who emigrates to a new land and who must build a new life within a new culture from the one left behind (Herman, 1992). Ask the client to apply this metaphor.
- c) Ask the client if he/she can make a “gift” of his/her experience to others? In what ways?
- d) “Crisis means a change in the flow of life. 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)
- e) “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)
- f) 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."
 - g) 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.
 - h) 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 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."

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INTERNET RESOURCES

Psychotherapy and Spirituality Institute
<http://www.mindspirit.org/>

Psychology of Religion Pages
<http://psychwww.com/psyrelig/index.htm>

ADDENDUM II

BOLSTERING RESILIENCE IN HELPERS: USING INDIVIDUAL, SOCIAL AND ORGANIZATIONAL INTERVENTIONS TO ADDRESS VICARIOUS TRAUMATIZATION AND JOB STRESS

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OUTLINE

Conceptualization of Vicarious Traumatization (VT): Relationship to Related Constructs (Secondary Traumatic Stress, Compassion Fatigue, Burnout, Countertransference)

**Most Common Reactions of VT
Feelings, Cognitions, Behavior, Organizational Indicators**

**Vulnerability to VT
Characteristics of the Client, Job, Helper
Helper can engage emphatically**

**Assessment Tools
Measures and Self-assessment of VT**

**Interventions: Ways to Cope with VT
General Guidelines
Measure of Resilience Indicators for Helpers
Individual Level
Peer and Collegial Level
Organizational and Agency Level**

References

Websites

CONCEPTUALIZATION

Milton Erickson used to say to his patients, “My voice will go with you.” His voice did. What he did not say was that our clients’ voices also go with us. Their stories become part of us – part of our daily lives and our nightly dreams. Not all stories are negative - indeed, a good many are inspiring. The point is that they change us. (Mahoney, 2003, p. 195).

Vicarious Traumatization (VT) – defined by Pearlman and Saakvitne (1995, p. 31) as the “cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client’s traumatic material.” Empathy is the helper’s greatest asset and also possibly his/her greatest liability.

VT is not the same as burnout, although burnout may be exacerbated by VT. VT places more emphasis on changes in meanings, beliefs, schemas and adaptation, and VT is more likely to lead to imagery intrusions and sensory reactions. Hatfield, Cacioppo and Rapson (1994) describe the type of emotional contagion that may lead psychotherapists to the “catching” of emotions of their clients. VT permanently transforms helpers’ sense of self and their world. VT can influence Countertransference responses.

Secondary Traumatic Stress – adverse reactions to trauma survivors who they are helping or wanting to help. Figley (1995) called this **compassion fatigue**. Secondary Traumatic Stress is often used interchangeably with VT, although VT implies more permanent than temporary stress responses (See Stamm, 1999).

Burnout is conceptualized as a defensive response to prolonged occupational exposure to demanding interpersonal situations that produce psychological strain and provide inadequate support. Reflected as “energy depletion” with mental and physical exhaustion resulting from job strain, erosion of idealism and a reduced sense of accomplishment and achievement.

Countertransference implies that the helper’s response is influenced by the helper’s own unresolved issues (e.g., lingering impact of the helper’s victimization experiences). This may lead to avoidance and overidentification with the patient. The helper may take on a protective role for the client, becoming the “champion” of the client and adopt a role of “rescuer.” The helper may inadvertently become a “surrogate frontal lobe” for the client.

CAVEAT: STATUS OF THE CONCEPT OF VT

While the concept of VT has received widespread attention (Arvey, 2001; Blair & Ramones, 1996; Danieli, 1988; Neumann & Gamble, 1995; Norcross, 2000; Pearlman & MacLan, 1995; Schauben & Frazier, 1995; Sexton, 1999; Stamm, 1997) leading to various self-help books for mental health workers (Herbert & Wetmore, 1999; Saakvitne & Pearlman, 1996), Sabin-Farrell and Turpin (2003) provide a number of cautionary observations that are critical to keep in mind.

“There is yet no one questionnaire that has been designed to measure the concept of VT as a whole.” (p. 469)

“Symptoms of PTSD, burnout and general psychological distress have been found by some studies, although most correlations are weak.” (p. 472)

“The evidence for VT in trauma workers is inconsistent and ambiguous.” (p. 472)

With these caveats in mind, there does appear to be some mental health workers for whom the work is traumatizing. It can cause PTSD symptoms, particularly intrusive symptoms, and more general symptomatic distress with disruptions in beliefs concerning safety, trust and world view. Helpers who have a personal trauma history, who are newer to work, who have had little or no past or ongoing supervision, and who experience high job related stress may be most vulnerable to VT.

MOST COMMON REACTIONS OF VT

Feelings

- Feel overwhelmed, drained, emotional duress, overloaded, exhausted
- Feel angry, enraged, and sad about client's victimization; these feelings linger
- Feel loss of pleasure, apathetic, depressed, despairing that anything can improve
- Overly involved emotionally with the client
- Feel isolated, alienated, distant, detached, rejected by colleagues
- Experience bystander guilt, shame, feelings of self-doubt, incompetence, ashamed

Cognitions

- Preoccupied with thoughts of clients outside of your work. Overidentification with the client. (Have horror and rescue fantasies.)
- Loss of hope, pessimism, cynicism, nihilism
- Question competence, self-worth, low job satisfaction
- Challenge basic beliefs of safety, trust, esteem, intimacy and control. Feel heightened sense of vulnerability

Behavior

- Avoidance, distancing, numbing, detachment, cutting clients off, staying busy
- May experience symptoms similar to those seen in clients (intrusive imagery, somatic symptoms)
- Impact personal relationships and ability to experience intimacy
- High overall, general distress level
- Overextend self and assimilate client's traumatic material
- Difficulty maintaining professional boundaries

Organizational Indications

- Job turnover
- Low morale
- Absenteeism
- Job Dissatisfaction
- Organizational contagion

VULNERABILITY TO VT

Characteristics of the Client

- Helper can engage in an emphatic fashion with the client's plight in the present and in the past
- Helper is most vulnerable to VT as they affectively empathize with the client as a victimized child
- Most "risky" clients who may trigger VT in helpers
 - Graphic details of trauma, especially sexual abuse, work with rape and torture victims
 - Intentional cruelty
 - Client reenactments in therapy of aspects of the trauma
 - Ongoing risk of further revictimization
- Work with survivors who were also perpetrators may result in the helper being more likely to have intimacy problems and feel sad

Characteristics of the Job

Job-Related Stressors that Increase the Risk of Developing VT

- Large caseloads – overextension due to work demands
- Large percentage of clientele who have trauma experiences and suffer PTSD
- Back-to-back clients who are trauma survivors
- Cumulative exposure to traumatized clients over time

- Absence of peer support and supervision
- Few resources available to refer clients for ancillary services
- Professional isolation
-
- Workplace structural and personal strains
- Reimbursement issues, managed care
- Legal consequences for helper
- Barriers to achieve interventions goals
- Barriers to the helper seeking help – concerns about confidentiality, fear of stigmatization

Characteristics of the Helper

- Personal victimization history that is unresolved – issues of shame, guilt, anxiety, anger
- Lack of experience – novice workers at greater risk
- Length of time working as a trauma counselor (mixed results)
- Lack of coping skills
- Current personal stress experience
- Helpers who are more aware of VT and countertransference are less susceptible to Secondary Traumatic Stress
- Additive effects of trauma and other stressors
- Level of subjective personal accomplishments – lack of fulfillment of goals. Create unobtainable goals.

ASSESSMENT TOOLS OF VT AND RELATED REACTIONS

Measures

Traumatic Stress Inventory (TSI-BSL)	Pearlman, 1996a
Traumatic Stress Inventory Life Event Questionnaire (LEQ)	Pearlman, 1996b
Compassion Fatigue Self-Test	Figley, 1995a
Maslach Burnout Inventory	Maslach, 1996
Secondary Trauma Questionnaire	Motta et al., 1999
Professional Quality of Life Scale (ProQOL)	Stamm, 2004 (<i>See website</i>)
Self-report Posttraumatic Stress Disorder Scale (PSS-SR)	Foa et al., 1993
Impact of Event Scale – IES	Horowitz et al., 1979
Trauma Symptom Checklist-40	Elliott & Briere, 1992
Symptom Checklist-90 (Revised SCL-90-R)	Derogatis, 1983
Brief Symptom Inventory	Derogatis, 1993

Self-assessment of VT

Review these questions with a trusted and supportive colleague.

“How am I doing?”

“What do I need?”

“How have I changed since I began this work?” (Positively, and perhaps, negatively?)

“What changes, if any, do I see in myself that I do not like?”

“Am I experiencing any signs of VT?” (See the list of common reactions.)

“What am I doing and what have I done to address my VT?”

“What are my specific goals when I think of my work with my clients? How successful am I in achieving these goals?”

“What is my sense of personal accomplishment in my work?”

“What work barriers get in the way of my having more satisfaction? How can these barriers be addressed?”

“How can I use social supports more effectively?” Draw a picture (web diagram) of your social supports on the job (colleagues) and in non job-related areas (family friends).

“For instance, have I talked to other people about my concerns, feelings and rewards of my job?”

“Who did I talk to (both in the past and now)? What were their reactions? What did he/she say or do that I found helpful (unhelpful)?”

“What were my reactions to their reactions?”

“Is there anything about my work experience or other stressful events in my life that I have not told anyone, that is ‘unspeakable’, that I have kept to myself (a secret)?” Try putting it into words, such as, “I haven’t shared it because ...” or “I am very hesitant to share it because ...” What is the possible ongoing impact, toll, emotional price of not sharing and working through these feelings?

“Is there anything about my stress experience that I keep from myself? Is there an area or event that I have pushed away or kept at arm’s length from myself? Is there anything that causes me to say, ‘I can’t handle that?’ What aspect of my life have I not put into words yet, that are still lurking in that corner of my mind?”

“How will sharing these feelings help?” Remember, what cannot be talked about can also not be put to rest!

INTERVENTIONS: WAYS TO COPE WITH VT

GENERAL GUIDELINES

- Issue is managing VT, rather than totally avoiding it.
- Emphasis should be on early identification and treatment, reducing long-term negative impact.
- Interventions need to be multi-leveled and should not be left up to the individual.
- Helper should not feel ashamed or guilty about experiencing VT. Attitude should be on validating and normalizing such reactions. Reframe VT as being a sign of being a committed and a sensitive helper.

WAYS TO COPE WITH VT: AN OVERVIEW

(See the next pages for a description of each coping strategy.)

I) INDIVIDUAL LEVEL: PRACTICE SELF-CARE

A. Increase Your Self-observations

1. Recognize and chart signs of stress: Vicarious traumatization and burnout.
2. Conduct self-analysis: Fill out self-report scales.

B. Engage in Self-care Behaviors

3. Engage in relaxing and self-soothing activities.
4. Ensure physical and mental well-being.
5. Have outside outlets.
6. Engage in healing activities in and outside of therapy.

C. Use Your Cognitive Abilities

7. Recognize you are not alone: Normalize and monitor your “story-telling narratives.”
8. Have realistic expectations to enhance feelings of accomplishment.
9. Adopt a more philosophical accepting stance.

10. Do not take on responsibility to “heal” your clients. “Midwife” metaphor.
11. Challenge negativity. Don’t play the blame game!
Find meaning and hope. Solicit “the rest of the patient’s story.”

D. Engage in Behavioral Activities

12. Balance composition of case loads (victims and non victims).
13. Limit overall case loads.
14. Share reactions with clients. Nurture therapeutic alliance.
15. When necessary, take time off.

II) PEER AND COLLEGIAL LEVEL

A. Helper Initiated Activities

16. Assess social support network.
17. Seek social support.
18. Provide support. Don’t over do it!
19. Use buddy system (especially novices).
20. Obtain peer supervision.
21. Engage in “debriefing.”
22. Participate in training opportunities.
23. Participate in agency building or community building activities.
24. Use a team for support.
25. If indicated, participate in time-limited group therapy.

III) ORGANIZATIONAL AND AGENCY LEVEL

26. Agency should be proactive.
27. Schedule team meetings – “emotional checkups.”
28. Distribute and decrease case loads.

29. Provide ongoing supervision, especially for novice workers.
30. Promote education and training.
31. Help foster spiritual renewal.
32. Maintain professional connections.
33. Address boundary issues.
34. Support “mission” activities.
35. Provide Stress Inoculation Training and General Resilience Training and Acceptance/Mindfulness Skills Training.

D) INDIVIDUAL LEVEL: PRACTICE SELF-CARE

“Self-care is a skillful attitude that needs practice throughout the day.” (Mahoney, 2003, p. 25)

A. Increase Your Self-observations

1. Recognize signs of incipient, vicarious traumatization (VT) and impact of job stress (Burnout). Chart warning signs. Take your “emotional temperature.” (See list of common reactions).
2. Conduct a self-analysis. (Fill out self-report measures of stress levels).

B. Engage in Self-care Behaviors

3. Engage in self-care behaviors such as relaxation exercises between clients. Engage in soothing activities like going for a massage. Leave work at work. Develop a ritual for the transition for leaving work at the office. As Mahoney (2003, p. 26) suggests, *“Even though you are likely to carry your clients' struggles with you after work, learn to formalize a transition from your profession to your personal life (a walk, a prayer, a brief period of meditation, etc.).*
4. Ensure physical and mental well-being (nutrition, sleep, relaxation, creative expression, use humor). Replenish by having a get away weekend or vacation. Give yourself permission to escape when necessary. Cherish your friendships and intimacy with family.
5. Have some outlet for discharge outside of your clinical role (exercise, writing, building, gardening, family, social action). Engage in activities that are positive and that have concrete outcomes or products that foster a sense of accomplishment. Have a vocational avenue of creative and relaxing self-expression in order to regenerate energies.
6. Engage in healing activities that renew meaning of life both in therapy and out of therapy settings. For example, some therapists report bringing signs of life and beauty into their offices that remind them of beauty and rebirth. Engage in life-generating activities outside of therapy, such as gardening, painting, enjoying nature.

C. Use Your Cognitive Abilities

7. Recognize that you are not alone in experiencing vicarious traumatization (VT) and in experiencing job stress. Validate and normalize your reactions. It is not that you experience VT and job

stress, but what you tell yourself and others about your reactions. Listen for the “stories” (narratives) you tell yourself and others.

8. Have realistic expectations for yourself and your clients. Recognize your limitations. The percentage of goals and subgoals achieved is critical to foster feelings of accomplishment.
9. Adopt a more philosophical or religious outlook. Use your spirituality. Accept those aspects that cannot change, and work on those aspects that are potentially changeable, and as the adage goes, “know the difference.” Take pride in the work you do in helping serve human development. Honor the privilege of the helping profession.
10. Remind yourself that you cannot take responsibility for the client’s healing, but rather you should act as a “midwife” on the client’s journey toward healing. Remind yourself that there are some things (like traumatic grief) you can’t fix. ***“People in deep grief want to feel that you have heard their pain. If you try to ‘fix it,’ you may rob them of that passage. They often want someone they can trust, cry with, confess to, someone who is nonjudgmental. Remember it is a privilege to be part of the healing process,”*** as noted in Gail Sheehy's (2003, p. 366) moving account of the aftermath of September 11.
11. Challenge negativity. Minimize self-blame and blame in others. Examine feelings of shame, guilt, incompetence, frustrations. See stressors as problems-to-solved or use acceptance strategies and not as occasions to “catastrophize.” Focus on finding meaning and hope by attending to the client’s “rest of the story.”

D. Engage in Behavioral Activities

12. Where possible, balance the composition of victim and non-victim caseloads. Diversify your caseloads
13. If possible, limit overall caseloads.
14. Where appropriate, share reactions with the client. For example, the helper can comment to the client:

“Sometimes there is a part of me (the helper) that does not want to hear that such horrific things happened to you (the client). But there is another part of me that says that we must continue because it is important, and moreover, doing so is part of the healing process. But, I would not be honest with you (the client) if I did not comment

that no one should have suffered, nor endured, what you have experienced.

I am heartened by your willingness, ability, and your courage to share your story as part of the healing process.

I am also impressed to learn about the “rest of your story” of what you did to survive. As I have come to know you in spite of X (specific victimization experiences) you have been able to (highlight specific examples of resilience).

Such helper statements to the client can foster a stronger, respectful, collaborative therapeutic alliance as the helper conveys empathy and humanity. Such statements also convey to the client that his/her reactions are not unique, that the client is being “heard” and that the helper’s reactions are also not unique.

The helper can also go on and ask the client’s permission to share (make a gift of his or her experiences and suffering to others) – find meaning in -- The helper can ask the client:

I would like to ask you a question. Could I obtain your permission to share what you did to survive, to keep going in spite of X, with my other clients or with my colleagues? I would not mention your name and I would describe your situation in very general terms so no one could identify you. But, I would like them to benefit from your example. Would it be okay to “make a gift” of what you have done with others I see? Would that be okay?

15. Be gentle with yourself. Find a comfortable pace. Make yourself comfortable at work and at home. Give yourself permission to be cared for and counseled. Enjoy yourself. Finally, when necessary, take time off from work. Come back to work gradually.

II) PEER AND COLLEGIAL LEVEL

A. Helper Initiated Activities

16. Taking stock. Assess your network of supportive people at work and outside of work. Draw a map of supportive people. Who is there to provide emotional, informational, material supports? Note, it may not be the same folks for each type of support. What is your “game plan” to access and use supports? Who are the people in your life who can provide a “holding environment?”

17. Seek peer support. Talk with colleagues and friends. Maintain connections with others.
18. Don't be embarrassed or ashamed to ask for support, as well as reciprocate and offer support to others. Don't overdo it or you can increase your level of caregiver stress.
19. Use a buddy system at work, especially if you are a novice helper. Novices should be buddied up with more experienced helpers. Identify a colleague with whom you can discuss your work, its challenges and rewards.
20. Obtain peer supervision. Review cases on a regular bases.
21. Beyond case reviews, engage in "debriefing" (either informally or formally) around difficult and challenging cases (e.g., where threat of violence is an issue). In such debriefings the following questions can be addressed:
 - "What is it like to work with "traumatized" clients or with client families who experience multiple problems or who have diagnoses of Borderline Personality Disorder?"***
 - "What is most difficult or challenging in such cases?"***
 - "What is most rewarding in working with these clients?"***
 - "What do you (the helper) need right now?"***
 - "How can we (other helpers, friends) be of most help?"***
22. Participate in educational and training group forums about vicarious traumatization and job stress, focusing on possible solutions. (Do not just attend group sessions that can lead to "emotional" contagion.)
23. Participate in agency building or community building activities. Join others around a common purpose or value.
24. Use a team for support, join a study group, attend continuing education conferences and workshops.
25. The use of time-limited group therapy can be helpful for helpers who have a history of trauma, who are being most impacted as a result of working with traumatized clients and who experience high job stress. The group can address self-doubts, countertransference issues and varied levels of coping. Engage in self-analysis and use personal

therapy. Ask for and accept comfort, help and counsel. Find others whom you trust to talk to. If you can't find a therapist, create an imaginary one (who doesn't charge too much). Embrace your spiritual searching.

III) ORGANIZATIONAL AND AGENCY LEVEL

26. Agency should be proactive in recognizing and accepting vicarious traumatization, and job-related stressors.
27. Regularly schedule team meetings and support groups that include "emotional checkups."
28. Work toward distributing and decreasing the number of demanding victimized clients.
29. Provide ongoing supervision and mentoring (buddy system), especially for novice workers.
30. Promote education and training about vicarious traumatization and wellness programs.
31. Help workers seek spiritual renewal.
32. Maintain professional connections and identity. Collaborate with other helping agencies to foster a sense of a team working toward common objectives.
33. Conduct meetings and run workshops on boundary issues between clients and helpers in order to reduce this source of stress. Assist helpers to limit their exposure outside of work.
34. Agency can support a "mission" and accompanying activities to actively change the circumstances that lead to victimization. This may be done at the local, organizational and national levels such as advocating for legislative reform and social action. Help workers transform stress into ways of finding "meaning" and "purpose."
35. Provide Stress Inoculation Training for workers (See Dane, 2000; Meichenbaum, 1994, 2001, 2003) and General Resilience Training (see Reivich and Shatte, 2002). Reivich and Shatte highlight that resilience is a "mind set" and they describe how a variety of cognitive and affective factors can block or erode resilience. They propose 7 skills designed to nurture resilience including:
 - (a). Self-monitoring your thinking processes;

- (b). Avoid “thinking traps” such as blaming yourself or others, jumping to conclusions, making unfounded assumptions, and ruminating;
- (c). Detect “icebergs” or deeply held beliefs that lead to emotional overreactions;
- (d). Challenge these assumptive beliefs and examine the “if ..then” rules that are implicitly accepted; rather engage in problem-solving that is “realistically optimistic;”
- (e). Put events into perspective;
- (f). Learn ways to stay calm and focused;
- (g). Practice skills in real life as you change counterproductive thoughts and behaviors into more resilient thoughts and behaviors.

The need to learn to use acceptance and meditative–mindfulness skills should be employed. The mindfulness training helps individuals to accept things as one finds them, nurtures perceptual clarity and freedom from the judgmental aspects of language. These coping procedures call upon individuals to treat thoughts as “just thoughts.” These highlight the value of diminishing self-absorption, being less defensive, more open to experience, and more accepting. They cultivate moment-to-moment attention. (See Hayes et al., 1999; Kabat-Zinn, 1990; Salmon et al., 2004).

The **Stress Inoculation Training** procedure (Meichenbaum, 2003) that has been used to reduce job stress incorporates these varied cognitive-behavioral skills in a three phase intervention:

Phase I – Initial Conceptualization that collaboratively educates individuals about the nature and impact of stress and coping;

Phase II – Skills acquisition and consolidation where individuals can acquire and practice both intrapersonal and interpersonal coping skills that follow from the initial conceptualization phase;

Phase III – Application Training where individuals in groups can practice the coping skills, both in the training sessions and in vivo. These application trials should be as similar as possible to the real life demands, activities and settings.

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American Psychological Association Help Center

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

Tapping Your Resilience in the Wake of Terrorism: Pointers for Practitioners

<http://www.apa.org/practice/practitionerhelp.html>

Professional Quality of Life Scales assess job satisfaction, burnout and secondary stress reactions

<http://www.isu.edu/~bhstamm/tests.htm>

National Institute for Occupational Safety and Health

<http://www.cdc.gov/niosh/stresswk.html>