



THE GLENDON ASSOCIATION



Treatment of Individuals with PTSD, Complex PTSD, and Comorbid Disorders: A Life-Span Approach

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POLL 1

Have you seen or heard of
Dr. Meichenbaum before?

Conceptualization of PTSD

- Issues concerning Criterion
- Issues of “Criterion-creep”
- Most individuals (70%+) do not develop PTSD
- Question Diagnostic Criteria A2- - involving fear, horror and helplessness
- Issue of symptom overlap and comorbidity
- Little evidence of delayed onset PTSD
- No evidence of special mechanisms of traumatic memories, nor claims of “body memories”
- Search for biological markers has not proven successful.
- Need for cultural/racial, gender and developmental factors in assessment and treatment

Treatment Issues

- Equivalent Outcomes of Treatments for PTSD and Complex PTSD. Dismantling studies fail to identify active ingredients (DTE, CPT, PCS, EMDR, as examples).
- Consideration of **ACRONYM THERAPIES**
- Integrated Treatments for Patients with Comorbid Disorders
- Target-specific Interventions
- Spiritually-oriented Treatments and other treatment approaches
- Pharmacotherapies - have yielded limited positive results.

Treatment Issues

Treatments to Avoid

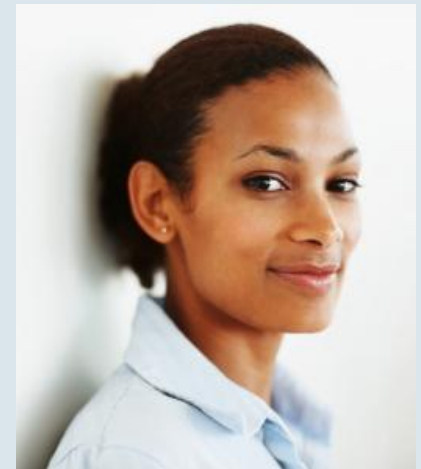
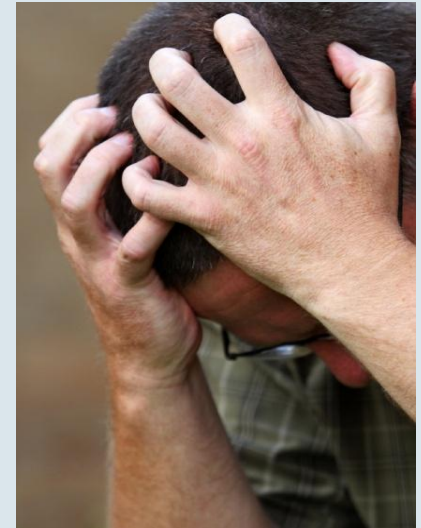
- CISD, Psychoeducational Interventions, “Energy-based” treatments such as Thought Field Therapy, Trauma Incident Resolution, Visual Kinesthetic Dissociation, Recovery-based Interventions, age regression, certain forms of grief counselling

How to Spot “Hype” In Psychotherapy Presentation

Presentation style; “Tricks of the trade” to oversell interventions; Check the nature of the Comparison Groups in Randomized Controlled Studies; Issues of Bonafide Treatments; Allegiance Effects; The “packaging” of interventions.

Implications for the Treatment of Individuals with PTSD, Complicated PTSD and Comorbid Psychiatric Disorders

- What distinguishes those who develop chronic disorders versus those who evidence Resilience? Implications for treatment?
- What are the common core competencies that cut across diverse interventions?
- What barriers interfere with the Natural Recovery process and how can these be anticipated and addressed?
- Critical role of a Case Conceptualization Model that informs ongoing assessment/evaluation and need for integrated treatment decision-making?
- Need for culturally, racially, gender and developmentally-sensitive interventions.
- How to become a “critical consumer” of the psychotherapy field? How not to be persuaded by “hype.”



“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Cognitive Level

- Engage in self-focused, “mental defeating” type of thinking. See self as a “victim”, controlled by uninvited thoughts, feelings and circumstances, continually vulnerable, unlovable, undesirable, unworthy - “Contaminated,” “Damaged goods”
- Hold erroneous beliefs that changes are permanent, the world is unsafe, unpredictable and that people are untrustworthy. Hold a negative, foreshortened view of the future and the belief that life has lost its meaning
- Engage in self-berating, self-condemnation, self-derogatory “story-telling” to oneself and to others (i.e., self blame, guilt-engendering hindsight, biased thinking; anger-engendering thoughts of viewing provocations as being done “on purpose”)
- Engage in upward social comparisons
- Ruminates repeatedly



“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Cognitive Level

- Engage in contra-factual thinking -“Why me” and “Only if”
- Engage in avoidant thinking processes of deliberately suppressing thoughts, using distracting behaviors, using substances; avoidant coping behaviors and dissociation.
- Have an overgeneralized memory and recall style which intensifies hopelessness and impairs problem-solving.
- Engage in “thinking traps”. For example, tunnel vision as evident in the failure to believe anything positive could result from trauma experience; confirmatory bias as evident in the failure to retrieve anything positive about one’s self-identity
- Evidence “stuckiness” in one’s thinking processes and behavior. Respond to new situations in post-deployment settings “as if” one was still in combat (misperceive threats).

“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Emotional Level

- Engage in emotional avoidance strategies
- Magnify and intensify your fears and anger
- Experience guilt (hindsight bias), shame, complicated grief, demoralization
- Fail to engage in grief work that honors and memorializes loved ones or buddies who were lost
- Fail to share or disclose feelings, process traumatic memories



“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Behavioral Level

- Engage in avoidant behaviors of trauma-related feelings, thoughts, reminders, activities and situations; dissociating behaviors
- Be continually hypervigilant
- Engage in safety behaviors that interfere with the disconfirmation of emotional beliefs
- Engage in delay seeking behaviors. Avoid seeking help. Keep secrets and “clam up”
- Engage in high risk-taking behaviors
- Engage in health-compromising behaviors
- Engagement in self-handicapping behaviors
- Use passive, disengaged coping behaviors



“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Social Level

- Withdraw, isolate oneself, detach from others
- Perceive yourself as being unwanted, a “burden”, thwarted belongingness, distrusting others (“No one cares”, “No one understands,” “No one can be trusted.”)
- Associate with peers and family members who reinforce and support maladaptive behaviors. Put yourself in high-risk situations
- Experience an unsupportive and indifferent social environment
- Fail to seek social support or help, such as peer-related groups or professional assistance



“HOW TO” DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

At the Spiritual Level

- Fail to use your faith or religion as a means of coping
- Have a “spiritual struggle”
- Use negative spiritual coping responses
- Experience “moral injuries” that compromise values
- Avoid contact with religious members who can be supportive



Psychological Characteristics of Resilient Individuals

Experience Positive Emotions and Regulate Strong

Negative Emotions

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

Adapt a Task-Oriented Coping Style

- Present-focused, acceptance, actively seek help and garner social supports, have a resilient role model, have self-efficacy, self confidence, seek out new and challenging experiences, evidence "GRIT."

Be Cognitively Flexible

- Reframe, redefine, restory, find benefits, engage in social problem-solving.

Undertake a Meaning-Making Mission

- Create meaning and a purpose in life. Use one's faith, spirituality, and values as a "moral compass." Be altruistic and make a "gift" of one's experience. Share one's story.

Keep Fit and Safe

- Exercise, reduce risks, avoid unsafe high-risk behaviors



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

1. Develop a collaborative therapeutic relationship/alliance and help the patient "tell" his/her story. After listening attentively and compassionately to the patient's distress and "emotional pain", help the patient identify "strengths" and signs of resilience. ***"What did he/she accomplish in spite of ...?" "How was this achieved?"*** Use Socratic Questioning.

- i. Foster bonding between patient and therapist. Address any ruptures or strains in the alliance and address any therapy-interfering behaviors.
- ii. Collaborate with the patient in establishing treatment goals and the means to achieve these goals.
- iii. Encourage the patient's motivation to change and promote the patient's belief that therapy can help. (Use Motivational Interviewing Procedures).
- iv. Monitor the patient's progress and use the information to guide ongoing treatment.

2. Be culturally-sensitive



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

- 3. Educate** the patient about his/her problems and possible solutions and **facilitate awareness**. Use various ways to educate and nurture a sense of curiosity and discovery.
- i. Conduct Risk and Protective Factors assessment and provide constructive feedback.
 - ii. Use a Case Conceptualization Model and share therapy rationale.
 - iii. Have the patient engage in self-monitoring.
 - iv. Use videotape modeling films and other educational materials.
 - v. Use a “Clock metaphor” – “Vicious Cycle” Model (*see next slide*)
 - vi. Therapist models thinking: Ask the patient: “Do you ever find yourself, out there, in your day-to-day experience, asking yourself the kind of questions that we ask each other right here?”
 - vii. Educate the patient about relapse prevention strategies.



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

“Clock metaphor” – “Vicious Cycle” Model

12 o'clock - external and internal triggers

3 o'clock - primary and secondary emotions

6 o'clock - automatic thoughts, thinking patterns and schemas or beliefs

9 o'clock - behaviors and resultant consequences



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

His/her appraisal of situations, feelings, thoughts, and behaviors are all interconnected.

“Collect data” (self-monitor).

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

“Break the cycle.” What did you have in mind?”, the therapist can ask. The therapist can help the patient come to appreciate how he/she has already been trying to “break the cycle.”

Primary and secondary emotions

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

What is the impact, the toll, the price he/she and others pay? Is that the way he or she wants things to be? If not, then what can be done about it?” - “art of Socratic questioning”

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

4. Help the patient **reconceptualize** his/her "problems" in a more **hopeful** fashion.
 - i. Do a life-review (*Use Time-lines – see next slide*)
 - ii. Use collaborative goal-setting (short-term, intermediate, long-term goals)
 - iii. Use videotape coping modeling films
 - iv. Use letter-writing, journaling
 - v. Use group processes – open-ended groups
 - vi. Use Alumni clubs of successful patients (coping models)
 - vii. Use hope-engendering mentors



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

Timelines:

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

Timeline 2 – Birth to present. Note “strengths” and “*In spite of*” and use “*How*” and “*What*” questions.

Timeline 3 – Present into future

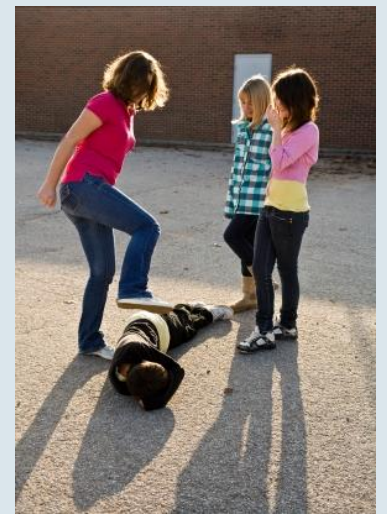
Highlight: How things are now and how would the patient like them to be in the future?

The therapist can go on to ask:

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

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

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



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

5. Ensure that the patient has intra- and interpersonal **coping skills**
 - i. Highlight the discrepancy between valued goals and current behavior and consequences and consider what can be done to close this gap.
 - ii. Train and nurture specific skills to the point of mastery.
 - iii. Build in generalization.
 - iv. Put the patient in a consultative mode.



6. Encourage the patient to **perform "personal experiments"**
 - i. Solicit change talk
 - ii. Facilitate “corrective emotional experiences”
 - iii. Involve significant others.
 - iv. Ensure that the patient takes the "data" to unfreeze his/her beliefs.

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

7. Ensure that the patient **takes credit** for change

- i. Use attribution training
- ii. Nurture a sense of mastery and efficacy (*“In spite of ... How ...?”*)
- iii. Monitor the degree to which the patient ascribes personal agency for change.
- iv. Help the patient change his/her personal narrative

8. Conduct **relapse prevention**

Additional Psychotherapeutic Tasks for Treating Psychiatric Patients
With

a History of Victimization.

9. Address **basic needs** and **safety - symptom regulation**

- i. Conduct an **integrated treatment** program
- ii. Normalize, validate and reframe symptoms as a means of coping



CORE TASKS OF PSYCHOTHERAPY: WHAT "EXPERT" THERAPISTS DO BASED UPON THERAPEUTIC PRINCIPLES OF CHANGE

10. Address "memory work" and help with the patient's belief system

- i. "Retelling" trauma story
- ii. Relive with cognitive restructuring
- iii. Consider what implications (beliefs) the patient has drawn
- iv. Consider impact of "shattered assumptions"

11. Help the patient find "meaning": Adopt a constructive narrative perspective

- i. Consider what the patient did to "survive"
- ii. What evidence of strengths in self and in others
- iii. What "lessons" learned that the patient can share with others
- iv. What is the role of faith



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

12. Help the patient re-engage and "reconnect" with others.

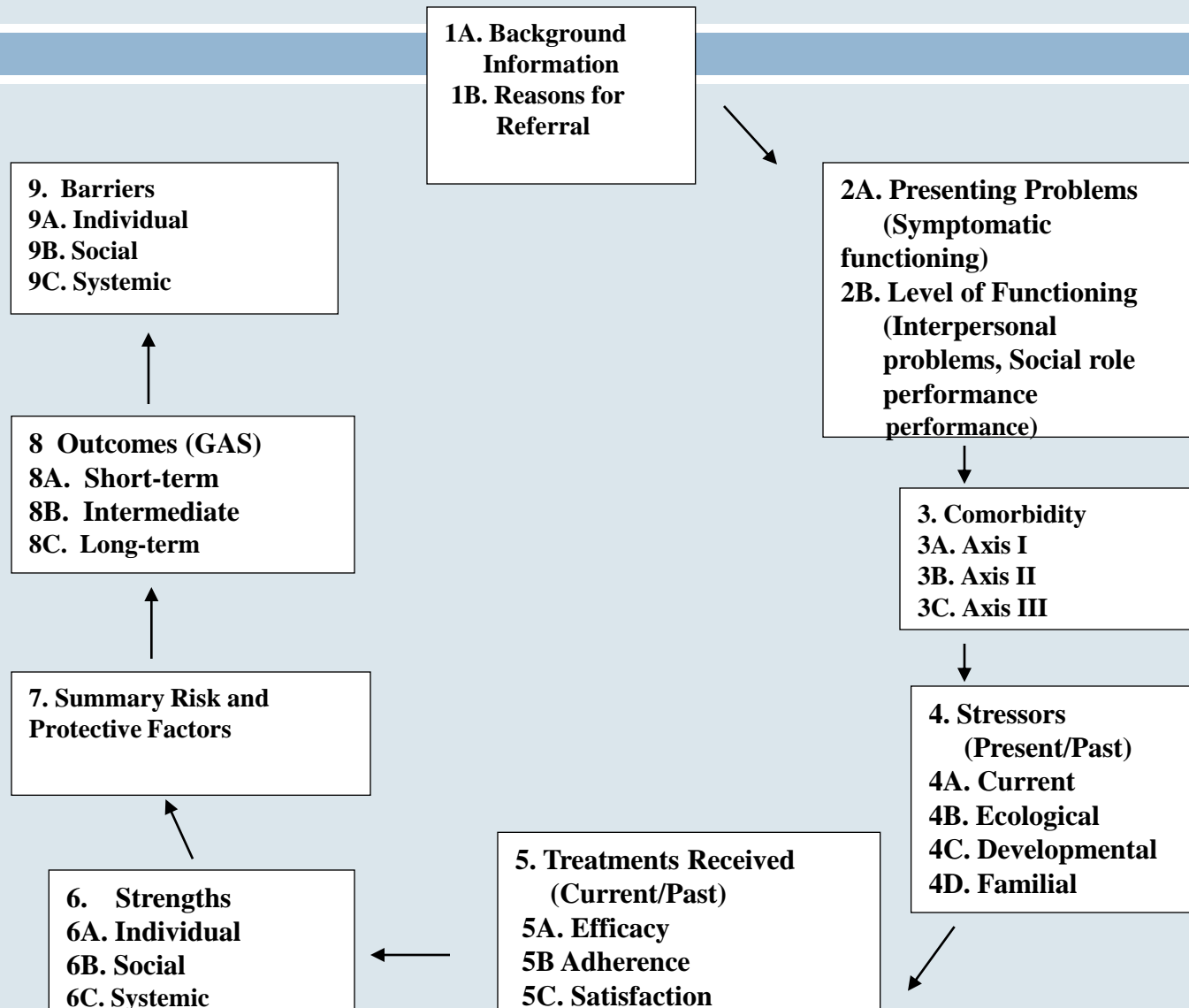
- i. How to move beyond the "victim" role to that of becoming a “survivor”, even a “thrivor”
- ii. How to engage in a proactive "helper" role
- iii. How to connect with **adaptive/supportive** peers and community resources



13. Religion or spirituality

14. Help the helpers. “Expert” psychotherapists monitor, assess and attend to the impact of vicarious traumatization.

GENERIC CASE CONCEPTUALIZATION MODEL



BOXES 1 & 2: REFERRAL SOURCES & PRESENTING PROBLEMS

“What brings you here is ...?”

“And is it particularly bad when...”

“But it tends to improve when you...”

“And how is it affecting you?”



BOX 3: COMORBIDITY

“In addition, you are also experiencing...”

“And the impact of this in terms of your day-to-day experience is...”



BOX 4: STRESSORS

“Some of the factors (stresses) that you are currently experiencing that seem to maintain your problems are...”

“And it's not only now, but this has been going on for some time, as evident by...”

“And it's not only something you have experienced, but your family members have also been experiencing...”

“And the impact on you has been...”

BOX 5: TREATMENT RECEIVED

“For these problems the treatments that you have received were...”

“And what was most effective?”

“But you had difficulty following through with the treatment as evident by...”

“And some of the difficulties (barriers) in following the treatment were...”

“But you were specifically satisfied with...”

BOX 6: STRENGTHS

“But in spite of...you have been able to...”

“Some of the strengths...”

“Moreover, some of the people (resources) you can call upon (access)are...”

“And they can be helpful by doing...” (Social supports)



BOX 7: SUMMARY OF RISK AND PROTECTIVE FACTORS

“Have I captured what you were saying?”

“Of these different areas, where do you think we should begin?”



BOX 8: OUTCOMES (GOAL ATTAINMENT SCALING PROCEDURES)

“Let's consider what are your expectations about the treatment.

“How are things now in your life? How would you like them to be?”

“How can we work together to help you achieve these short-term, intermediate, and long-term goals?”

“What has worked for you in the past?”

“How can our current efforts be informed by your past experience?”

“Moreover, if you achieve your goals, what would you see changed?”

“Who else would notice these changes?”

BOX 9: POSSIBLE BARRIERS

“Let me raise one last question, if I may. Can you envision, can you foresee, anything that might get in the way?”

“Let's consider how we can anticipate, plan for, and address these potential barriers.”

“Let us review once again...”

Reassess with the patient the treatment plan throughout treatment.

POLL 2

Do you think this approach to case conceptualization could be beneficial for your clients? And for you in planning effective interventions?

- Very helpful
- Somewhat helpful
- Not helpful

OVERVIEW OF TREATMENT

INITIAL PHASE I

- Establish, maintain and monitor therapeutic alliance. Address therapy interfering behaviors and potential barriers.
- Ensure client safety: Ongoing Risk assessments and assess for comorbid disorders.
- Address immediate needs and provide assistance.
- Normalize and validate client's experiences.
- Educate the client about presenting problems and about treatment.
- Nurture Hope. Use Time Lines and related procedures.
- Collaboratively generate "SMART" treatment goals.

PHASE II

- Address target symptoms of PTSD and Complex PTSD.
- Address comorbid-disorders in an integrated treatment fashion.
- Teach and nurture intra and interpersonal coping skills.
- Focus on Affect Regulation Skills.
- Bolster resilience-engendering behaviors
- Address treatment adherence issues.

OVERVIEW OF TREATMENT

PHASE III

- Address issues of traumatic memory and meaning-making.
- Use exposure-based interventions.
- Use Cognitive Reconsideration and Cognitive-restructuring
- Help develop “Healing Stories.”
- Use spiritually-oriented interventions. “Meaning-making” activities.
- Help the client develop and mobilize supportive relationships. “Connectedness”

PHASE IV

- Use client Checklists and nurture self-attribution processes.
- Re-visit Relapse Prevention procedures. “Anniversary effects”.
- Build in follow-up and follow-through procedures. Ensure continuity of care.
- Bolster Health Care Procedures’ Resilience: Help the Helpers

POLL 3

Do you help your clients create healing stories?

- Yes, most of the time
- Yes, sometimes
- No

HOW TO CREATE A “HEALING STORY”

We don't just tell stories, stories tell us. The tales we tell hold powerful sway over our memories, behaviors and even identities

1. Their traumatic narrative is inadequately integrated into their autobiographical memories.
 - ▣ “Hot spots” and “stuck points”
 - ▣ **BACKFIRE** and **BOOMERANG**
2. **RESILIENT** - psychologically agile and flexible in how they tell their stories.
3. Resilient individuals may take some time to experience grief or unhappiness, distress, anger and loss, sadness and anxiety which improves their abilities to better appreciate the world in all of its complexity and richness.
4. Resilient individuals - redemptive sequences vs. contamination sequences
5. Resilient individuals slow down - break their experiences into pieces.
6. Resilient individuals - “open spaces” - guide to new goals and alternatives. Redemption stories bolster hope.



HOW TO CREATE A “HEALING STORY”

7. Resilient individuals - **COHERENT STORIES** that create meaning out of their stressful life experiences and in which they see themselves as “personal agents”, often with the assistance of others, of the positive changes that they have been able to bring about. These **COHERENT NARRATIVES** are 1. clearly articulated 2. detailed 3. logical and well organized. Such **COHERENT** stories are salutary and help reduce distress. They increase the survivor’s sense of control over his or her experiences, reduces feelings of chaos and increases the sense that the world is predictable. Provide “closure.”
8. Resilient individuals have the ability and penchant to tell their fragmented stories in a chronological narrative with a before, middle and post-trauma exposure or post-deployment parts. They are able to integrate what happened during deployment into their autobiographical memory and let the “past be the past.”
9. Resilient individuals avoid “thinking traps.” Instead they incorporate in their storytelling “cherished recollections,” “fond memories,” a “heritage of remembrances,” “change talk,” “lessons learned.”

HOW TO CREATE A “HEALING STORY”

10. Resilient individuals tell their stories first and then they live their way into them. They may act “as if” they are characters in the stories that they tell. There may be a certain amount of “fake it, until you make it.”
11. Do your stories include:
 - ▣ Redemptive (positive ending) sequences;
 - ▣ RE-words and change talk action verbs;
 - ▣ Goal statements and “how to” pathways thinking
 - ▣ Problem-solving strategies
 - ▣ Expressions of optimism
 - ▣ Meaning-making statements (“Making a gift”, “Sharing lessons learned” statements)?

POLL 4

Do you create a resilience checklist for your clients?

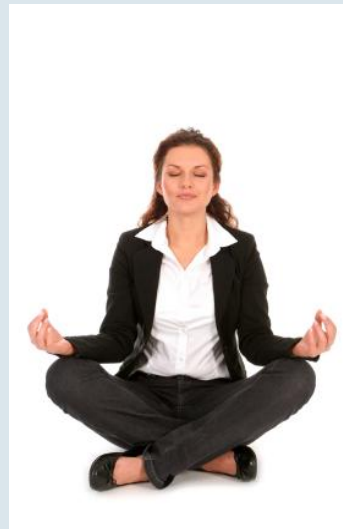
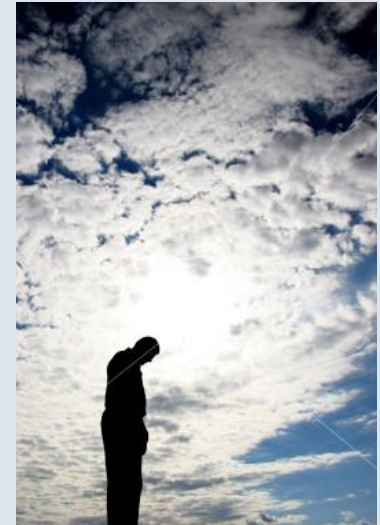
- Yes, most of the time
- Yes, sometimes
- No

RESILIENCE CHECKLIST

MY PERSONAL RESILIENCE PLAN

Creating a Vision of the Future

- ▣ PHYSICAL FITNESS
- ▣ INTERPERSONAL FITNESS
- ▣ EMOTIONAL FITNESS
- ▣ THINKING FITNESS
- ▣ BEHAVIORAL FITNESS
- ▣ SPIRITUAL FITNESS





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Dr. Daniel Siegel (1.5 CE Credits – \$35)



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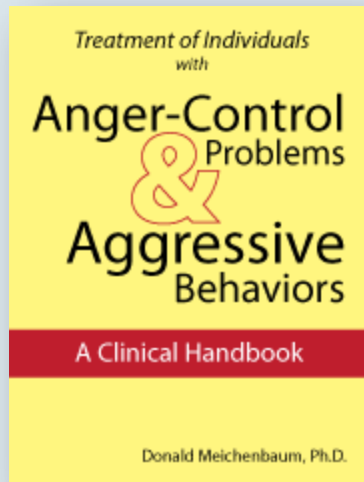
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Recommended Books

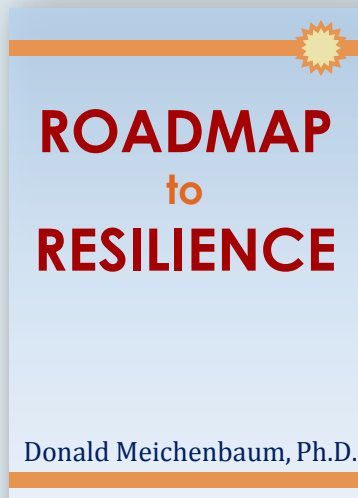


BOOK AVAILABLE from **Dr. Meichenbaum**
Clinical Handbook

*Treating Individuals with Anger Control
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Price \$65

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FORTHCOMING BOOK from **Dr. Meichenbaum**

Roadmap to Resilience

Book details will be emailed to you upon
availability



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- ❖ A recording of this webinar will also be available online. Those unable to attend this live webinar may view the recording and complete the evaluation form to receive 1.5 CE Units. You will be receiving 2.5 CE's upon completing the webinar and the post test material. The live webinar offers 1.5 CEs, while reading the additional articles we will be sending you by Dr. Meichenbaum offer an additional 1 CE.

You will receive an email from the Glendon Association, which will include:

- A satisfaction questionnaire to filled in and returned
- Articles by Dr Meichenbaum to be read
- Post- test, to be completed and returned

The post test and questionnaire need to be returned to the Glendon Association within 10 days

(The return information will be on the email)

If you have any questions please email Jina@glendon.org

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