Trauma Response Profile:

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Thousands of individuals from around the world including patients, professionals, and organizations have benefitted from the work of Donald Meichenbaum, Ph.D. Dr. Meichenbaum is Professor of Psychology at the University of Waterloo in Ontario, Canada and a member of The American Academy of Experts in Traumatic Stress. He was the innovator of Cognitive Behavior Modification (CBM) and at the forefront of the "Cognitive Revolution" in the field of psychology in the 1970s and 1980s. He was voted one of the ten most influential psychotherapists of the century by North American clinicians in a survey reported in the American Psychologist, the official publication of the American Psychological Association. Dr. Meichenbaum is Editor of the Plenum Press series on stress and coping and serves on the editorial board of a dozen journals. He has authored and coauthored numerous publications including the classic Cognitive Behavior Modification: An Integrative Approach (1977), Stress Reduction and Prevention (1983), Pain and Behavioral Medicine: A Cognitive-Behavioral Approach (1983), Stress Inoculation Training (1985), Facilitating Treatment Adherence: A Practitioner's Guidebook (1987), and more recently, A Clinical Handbook/Practical Therapist Manual For Assessing and Treating Adults with Post-Traumatic Stress Disorder (PTSD) (1994).

JSV: ***I know that you keep quite busy as a clinician, lecturer, consultant, researcher, and author. Can you tell me about the various roles and/or positions that you currently hold?***

DM: I am a Professor at the University of Waterloo who has recently retired. I am maintaining a full lab, as well as being a clinical consultant. I consult at a number of child, adolescent and adult programs, inpatient and outpatient, where a sizable percentage of the clientele have a history of victimization. I am also the Editor of a series for Plenum Press on stress and coping. And, perhaps, most exciting, I recently became involved as the Director of an Institute in Miami, Florida called "The Melissa Institute." Melissa was a young lady who was brutally murdered in St. Louis and her family has recently established an Institute in her name designed to explore issues on the prevention of violence and the treatment of victims of violence. The intent of the Institute is to bridge the gap between research findings and practical applications. The Institute is starting to take on more and more of a central role in my functioning. It ties directly into my work with victimized individuals.

JSV: ***When did you retire from the University?***

DM: Just this last July

JSV: ***Well, congratulations!***

DM: That's not the way my mother put it! My mother, who is 81-years old, works full-time in New York City. When I told her that I was retired, a perplexed look came upon her face. She said, "you're retired and I am working full-time. What am I going to tell my friends?" (*laughs*).

JSV: ***With so many exciting changes taking place in the area of traumatic stress (e.g., neurobiological***

findings, etc.), what things do you believe are in need of greater investigation?

DM: That is really a big question and I think the answer to it depends on which specific population one is looking at. I don't think that there are robust questions that cut across all populations. In general, at the level of adult, we need to examine the interrelationship between various spheres of behavior. That is, neurobiological, psychosocial, cognitive, and cultural. My own area of interest, as we will get into in a moment, is trying to better understand the cognitive arena. Once we have developed a metric for each of these areas, then we can start to look at the interdependence of these factors across domains. A second major area that needs to be explored that has not been looked at adequately, involves the fact that three-quarters of the population in North America is going to experience a Criterion A event some time in their life (*From the DSM-IV this relates to an event that a person experiences or witnesses that involves actual or threatened death or serious injury or threat to the physical integrity of self or others rendering the individual feeling helpless or fearful*). Yet, on average, only about 25% of people develop posttraumatic stress disorder (PTSD). An interesting and challenging question is what distinguishes those individuals who go on to develop PTSD from those who do not. I think that explicating those differences can be valuable in guiding both assessment and treatment. The third and final area involves the role of cultural factors in influencing the nature of traumatic responses and the ways in which these are expressed. As an Editor of the Plenum series, we have recently published a series of books on the cross-cultural and intergenerational features of traumatic stress. I think this latter area has also been overlooked.

JSV: ***I know that you have been a major proponent of the constructive narrative approach for the treatment of trauma survivors. Can you please describe the constructive narrative perspective and how it is utilized with your patients?***

DM: There are now a number of investigators from different perspectives who have been very sensitive and innovative in exploring the nature of the stories that individuals tell about their trauma. Those stories change over the course of time. The meaning that a traumatic event has for individuals is critical. This is not novel. A number of people have highlighted the role of appraisal processes and the role of the stories that people tell over the course of time. I have become particularly interested in how these stories change in my patients. I spend a good deal of time supervising clinicians - psychiatrists, psychologists, social workers- and we have audio taped and videotaped therapy sessions. We have noted that both symptom reduction and behavioral changes covary with the changing nature of the accounts that clients offer over the course of therapy. A sense of personal agency often emerges. Clients, over the course of therapy as they improve, often shift the focus of their accounts. They now move from viewing themselves as victims to becoming survivors if not - thrivers. As they do so they offer interesting accounts of how they can now often have many of the same kind of thoughts, feelings, intrusive ideation, etc. but this doesn't seem to bother them as much. They do not feel "stuck." There is a certain shift in the nature of their narrative. We have become very interested in tracking these changes. The challenge for us, at a research level, is whether these narrative changes are epiphenomena that follow behavioral changes and physiological changes or whether these narrative changes play an instrumental role in facilitating change. There are a number of investigators who have studied victims of natural disasters (Harvey), rape victims (Foa et al.), AIDS victims (Folkman and Stein), child sexual abuse victims (Janoff-Bulman and Silver), each of whom have highlighted the role of narrative changes. The challenge for the field is that, at this time, we don't know how best to analyze and code these narrative accounts. The constructive narrative approach is a set of clinical observations in search of a methodology and a theory. Let me conclude by saying that when bad things happen to people, the way they tell others, as well as tell themselves "stories" about the trauma, can influence their abilities to cope. Also note, that how people cope can influence the "stories" they tell. But often traumatized individuals struggle to put into words, or into some other form of expression, the impact of the trauma. In their attempt to convey their distress they often employ metaphors. "I am a walking time bomb." "I am a

victim of the past." "This event opened up a can of worms." "I am spoiled goods." "I feel like I am on sentry duty all of the time." Thus, in their own way, they become poets. But these metaphors become more than figments of speech. I believe they become ways in which individuals come to construe and construct "reality." One can view therapy as a way to elicit clients' stories and to help them change their narratives. In A Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Post-Traumatic Stress Disorder (referred to as the PTSD Clinical Handbook), I describe a variety of psychotherapeutic techniques to accomplish these objectives.

JSV: ***On that note, in 1994 you published A Clinical Handbook/Practical Therapist Manual for Assessing and Treating Adults with Post-Traumatic Stress Disorder. This compendium of information is magnificent. In fact, the Administrative Board of the Academy has recommended this publication for professionals across disciplines. What motivated you to develop that project and what were some of your most memorable moments as you were compiling it?***

DM: I do appreciate your evaluation and in fact, I have been quite pleased in how this volume has been received and reviewed. I have been a consultant for a number of years and in each setting I am called upon to give presentations or supervise cases. Given my obsessive-compulsive academic style and my commitment to science, I would put together various handouts on PTSD, depression, anger or addictive behaviors, etc. People would ask me about assessment instruments and interventions. In response, I would put together a rather extensive handout. The Clinical Handbook is the collection of these handouts integrated into a format that hopefully people will find helpful. You asked about the most anxiety-producing feature of putting together the PTSD Handbook. In each of the books that I had written previously, I had given them to a publisher. In this case, I decided to publish the Clinical Handbook myself. This led to some anxiety and I had to convince my wife that this high risk activity would not turn out to be a Criterion A event! In fact, it took an initial outlay of a large set of funds. In publishing it myself, the proceeds from the Handbook are now going toward the development of a research and clinical training institute. So I now have been able to use the royalties generated by the Handbook to support graduate students, innovative research, and expand training materials that clinicians may be able to use. My dream is that we will eventually computerize the Handbook so that clinicians will be able to access this on a CD-ROM and call up specific clinical problems, assessment issues, treatment concerns, and even watch CD-ROM movies of master clinicians demonstrating each of the core tasks of psychotherapy.

JSV: ***You have described how the "art of questioning is the most critical skill" for clinicians to develop. Why do you believe this is the case and how do you apply this skill in treating trauma survivors?***

DM: If you go back to my comments on the constructive narrative perspective, then the therapist's "art of questioning" is critical in eliciting and changing clients'narratives. It is important to encourage clients to "tell their stories" of what they have experienced and the impact on them, their families and communities. It is also important that the therapist elicit what Paul Harvey, the radio commentator, calls the "rest" of the story. Namely, what has the client been able to accomplish in spite of the trauma? A way to facilitate this disclosure is to have clients use a timeline (or life chart) where they can indicate when various traumatic events occurred in their lives. On a second time line, the clients can indicate what they have been able to accomplish in spite of these traumatic events. The therapist can not only elicit such accounts, but can then ask clients to describe in more detail what they had accomplished and how they were able to do this. "How" questions are especially helpful because they "pull" for the nature of the strengths that individuals have and they highlight the instrumental acts that individuals, couples, groups and communities have been able to implement to affect change. Thus, from my point of view, the "art of questioning" not only serves the function of assessment, but it sets the direction for change in the clients' narratives. Finally, it is hopeful that therapy will result in clients becoming their own therapists -

taking the clinician's "voice" with them. I will often ask clients if they ever find themselves out there in the real world, asking themselves the kinds of questions that we ask each other right here in therapy? We want clients to "internalize" the therapist's art of questioning.

JSV: ***Although many people are exposed to traumatic experiences in their lifetime, most do not develop posttraumatic stress disorder (PTSD). What factors do you believe "buffer" a person from developing full-blown PTSD?***

DM: When I give workshops, I review four classes of factors that I think distinguish those who develop PTSD from those who do not. The four general headings have to do with characteristics of the trauma itself. There is a good deal of research that highlights the nature of the objective features of the traumatic event including its intensity, its durability, and people's proximity to the event. Another important aspect of these stimulus characteristics is not only the objective features but also the subjective features. There are a number of studies that highlight that the meaning the event has may play more of a role than the actual stimulus characteristics. That is, does the individual feel that by their actions or lack of actions, that they may have inadvertently contributed to the traumatic experience? This can play an important role in determining who develops PTSD. For example, if the individual feels blameworthy and guilty about the nature of their role in the traumatic event, this would clearly increase the likelihood of people developing PTSD. So, one whole class of events involves stimulus characteristics. The second class of events are response characteristics. We know that the nature of the response that individuals have in reaction to the traumatic event is critical in determining who goes on to develop PTSD. There are three features that turn out to be important. One is how the person responded at the time of the traumatic event. What has notably been characterized as the acute stress reaction. Does the person show anxiety, dissociation and the like? This may play an important role in influencing the nature of the reactions they encounter and the support that they may receive.

Another element that becomes important is the recognition that the reactions of traumatized individuals change over the course of time. It is not only important to recognize that clients have symptoms, but when they have these symptoms is critical. For example, a common referral problem is intrusive ideation. Research by Baum and others indicates that if intrusive ideation occurs down the road, well after the event, it increases the likelihood of PTSD. Also, is there comorbidity? That is when the individual not only experiences what is considered classical PTSD, but what is known as complex PTSD. Are there comorbid responses such as anxiety, depression, suicidal ideation, and what is often overlooked, anger responses? Also, as I noted, are there guilt reactions? This clearly complicates the nature of the situation and increases the likelihood of developing PTSD.

Two other factors play an important role in determining who develops PTSD. There is a good deal of research to implicate the role of premorbid features; that is the nature of prior exposure to victimization increases the risk of developing PTSD. Whether one looks at the research on combat, or on being a victim of crime, or many other traumatic events, you find that prior exposure both for the individual and their family or community, can put individuals at high risk. There are a number of other premorbid features in terms of socialization patterns and the like that may also predispose individuals to develop PTSD. For example, intergenerational victimization becomes important. Some recent findings highlight that when children are victimized, if their parents have had a history of victimization, it increases the likelihood of the children developing PTSD. The last and perhaps the most overlooked factor is the nature of the recovery environment. It is not only what the person experienced and how they reacted both at the time or down the road, or whether this was the first time that they were traumatized or not. We must also consider the nature of the recovery environment - it can become critical. All we have to do is compare the reactions and welcome that Vietnam vets received versus those vets who came home from Operation Desert Storm. There is a clear need to explore the role that social support, community work and the like play. Another aspect that I think is overlooked, is the role that religion plays in helping

people cope with stress. I had spent some time in Oklahoma City and saw the role that the church played there. Moreover, in recognizing that the major way that people try to cope with trauma is by means of prayer or some kind of religious ritual, I believe this highlights the need for us to expand what constitutes the recovery environment.

JSV: ***As you are aware, investigation of the effects of traumatic stress in children is in its infancy. What issues do you think are in need of greatest attention in this area?***

DM: This is a big issue for me because I spend a good deal of time consulting at residential programs with children who have been victimized. The Melissa Institute is designed to identify high risk children and their families and communities and to develop prevention programs. So there is a good deal that I could say about this. I think that the major issue for me involves the changing scenario of urban settings in the United States where unemployment and violence, family dysfunction, poverty, racism, and the like, are so rampant. The epidemiological data highlights the widespread victimization of children. I don't think that we have fully appreciated the nature and impact of just how widespread traumatic stress is for children. Also, there is an increasing need to focus research on what constitutes resilience factors for these children. I think that explicating and building upon these resilience factors in terms of preventative programs would be most important.

JSV: ***We are learning more and more about the effects of secondary traumatic stress such that caregivers themselves become traumatized and/or overwhelmed through their efforts to assist others. What advice do you have for those who treat trauma survivors?***

DM: Let me enumerate them in point form. These are described in more detail in the Handbook. If in fact clinicians have the chance, they should not limit their practice just to trauma survivors. Given the challenge of this population and their often unresponsiveness to various forms of treatment and the harrowing tales that they have to tell, it would be helpful to include the more traditionally "neurotic" types of cases that are more treatment responsive in terms of anxiety, marital distress and the like. This is often not a possibility for trauma therapists but if it is, I would encourage clinicians to pursue it. Secondly, I think that therapists/clinicians could benefit from debriefing. That is, having the opportunity to share the impact of their trauma work. One of the things that we know from the research is that people who have had an opportunity to tell their story to significant others do better in the long run than those people who do not share their stories. That clearly is an emerging finding in the area of working with victims. Individual therapists can develop coping techniques both within sessions and between sessions and in spheres outside of therapy. This can renew their faith which can become challenged when dealing with trauma clients and horrific tales of evil. In the same way that we know trauma can affect the belief system and outlook of clients, I suspect it can have a similar impact on therapists.

JSV: ***What do you perceive as the most important factors for clinicians/professionals, including non-mental health personnel, to consider when intervening on behalf of a survivor of a traumatic event?***

DM: I think that the task of the health care provider changes in terms of when they intervene. If it is soon thereafter, then there are a number of emergency requirements. Moreover, the signature of the event becomes important as to how one would intervene. At first, it is important to make sure that people have information and that they are safe. The clinician or health care provider may act as a support agent and make sure that survivors are protected from the media and well-wishers who could make things worse. There is an immediate crisis that needs to be addressed. Then there is a second phase that has to do with education about the impact of the trauma. Education about PTSD and discussion about adaptive and maladaptive coping responses, while normalizing and validating the nature of people's reactions become important. As one proceeds, especially if the impact of the trauma occurs over

a prolonged period of time, a major concern is that health care providers often leave the scene too soon (i.e., see the research by Pennybaker). There are also concerns about potential secondary victimization and later on, anniversary effects. This is especially the case if the victimization experience is of intentional human design as compared to a natural cause. There is often an increased likelihood of anger that has to be addressed. How does one make sure there are no comorbid reactions such as addictive behaviors, depression, anxiety attacks and the like? It is important that mental health personnel recognize that people don't heal easily. You don't cure PTSD. You don't stop the memories. In fact there is some research that suggests that the more you intentionally try to stop traumatic memories, the greater likelihood that they are going to increase in terms of their intrusiveness. Therefore, the question is how do you help individuals transform memories? How do you help people find meaning in such events? How do you help them transform their pain into a "mission?" This is all subsumed under the constructive narrative perspective. If one sees the task of the health care provider in this broader view, then what you do right at that time of the event is only one small parcel of the total intervention.

JSV: ***As you are aware, The American Academy of Experts in Traumatic Stress is a multidisciplinary organization with more than one hundred professions represented. The Academy recognizes that traumatic events are an unfortunate part of the human experience that professionals and workers from many fields work with on a regular basis. What do you see as the major advantage of an organization such as the Academy that is dedicated to increasing awareness and ultimately, improving the treatment for survivors of such events across such an eclectic group?***

DM: Well, I think that providing an umbrella organization that will facilitate dialogue as you do both in your journal and in other events is a valuable service. What the physician, the emergency worker, and the psychotherapist have in common and how interventions can be coordinated across disciplines is a valuable service. Such a dialogue should result in better treatments for survivors and for those who provide such services.

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