WAYS TO BOLSTER RESILIENCE: A STRESS INOCULATION APPROACH

Donald Meichenbaum, Ph.D.

Research Director of the Melissa Institute for Violence Prevention, Miami

www.melissainstitute.org

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ROADMAP TO RESILIENCE (Click on Appendices A and B)

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PTSD: CONCEPTUALIZATION AND INTERVENTIONS

Please see www.melisainstitute.org CLICK on Resilience Resources for additional papers. Please see roadmaptoresilience.wordpress.com for a FREE copy of Meichenbaum's book Roadmap to resilience.

1. PTSD is essentially a disorder of non-recovery. In the aftermath of victimizing and traumatic experiences most individuals are impacted, but some 75% of such individuals evidence resilience or the ability to "bounce back" and meet the challenges of ongoing adversities.

2. PTSD is a reflection of an autobiographical memory of a recent or a distal incident of trauma. The body keeps score of the impact of trauma experiences, but the body also keeps a score of engaging in resilience-engendering behaviors such an emotion regulation activity, accessing social supports and engaging in meaning-making activities.

3. We are all not only Homo Sapiens but also HOMO NARRANS or storytellers. It is proposed that the nature of the stories that individuals, families and communities tell themselves and tell others in the aftermath of experiencing trauma influences whether resilience or PTSD will develop. It is not that people experience traumatic events, per se, but what lingers and what are the conclusions that they draw about themselves, others and the future that determines their long-term reactions.

4. Treatment interventions need to be culturally sensitive and should integrate spirituality and psychotherapy where indicated. The major way that individuals cope with loss in North America is to use some form of spirituality and religion. There is a need to tailor the therapeutic approach to the preferential implicit belief system of the patient. For example, comparison of immigrants from S. E. Asia Cambodia who prefer a "here and now" problem - solving treatment approach (not rehash the past) VERSUS immigrants from South America who sought accountability from perpetrators prefer using what is called a Testimony approach to treatment.

"Trauma is everywhere, but so is resilience and the good stuff is more important in predicating outcomes than the bad stuff"

5. Table 1 provides a list of behaviors that contribute to the development of PTSD and related psychiatric disorders. Any type of intervention that reduces the likelihood of engaging in such negative behaviors will prove effective. Treatments that encourage non-negative thinking enhances resilience (Change talk, the language of possibilities, and that encourage individuals, families and communities to access and employ the strengths they bring to therapy facilitates behavioral change). Some individuals will require supplemental skills training. Effective interventions are strengths-based and future-oriented. Table 2 enumerates the treatment implications of a Constructive Narrative perspective of the treatment of individuals with PTSD and Complex PTSD.

6. The quality of the therapeutic relationship is 3 to 4 times as important as the specific intervention that is employed.

7. Treatments for individuals with PTSD and Complex PTSD are filled with Acronym-based interventions, but no one treatment has been found to be more effective than any other treatment approach. "Here and Now:" skills-oriented interventions have been found to be a effective as "Then and There "type interventions. Moreover, the field of treating individuals with PTSD and related disorders is filled with HYPE and exaggerated claims of effectiveness. (Please visit the Melissa Institute Website www.melissainstitute.org in order to read the article "How to spot HYPE in the field of psychotherapy: A consumer' checklist.")

8. Treatment does not cure individuals with PTSD, but rather helps them retrieve positive strengths-based autobiographical memories in which to embed traumatic memories.

9. ALL forms of effective interventions for individuals with patients with PTSD and Complex PTSD involve both talk (cognitive and emotional components). It is NOT an either-or treatment approach. All effective interventions bolster patient's resilience in multiple domains (physical, interpersonal, emotional, cognitive, behavioral and spiritual).

HOW TO DEVELOP PERSISTENT PTSD and RELATED ADJUSTMENT PROBLEMS

If we can determine what factors contribute to persistent and chronic PTSD and related adjustment difficulties, then we can figure out what leads individuals to get "stuck." We can then determine how to help these individuals get "unstuck" and develop RESILIENCE. Let us consider what factors come into play at the cognitive, emotional, behavioral and spiritual levels. HOW MANY OF THESE ACTIVITIES DO YOU ENGAGE IN?

<u>At the Thinking Level</u>

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

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

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

Engage in upward social comparisons, so one compares poorly in one's coping abilities. Be preoccupied with what others think of you. Engage in comparison of self <u>versus</u> others; before <u>versus</u> now; now <u>versus</u> what might have been.

Ruminate repeatedly, dwell on, focus upon, brood, pine over losses, near miss experiences. Replay over and over your concerns about the causes, consequences and symptoms related to negative emotions and losses. Use repetitive thinking cycles (loss spiral). Hold the belief that you cannot do anything to control such thoughts. (My thoughts are like a movie that never stops. This is like a form of self-punishment that I deserve.) Focus on your regrets.

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

Engage in avoidant thinking processes of deliberately suppressing thoughts, using distracting behaviors, using substances; avoidant coping behaviors and dissociation (spaced out behaviors). Fear your memories and accompanying feelings and engage in avoidant behaviors.
Fail to challenge your fears, nor invite them to tea.
The more one attempts to suppress cognitive material, the more that material intrudes into consciousness, like a boomerang rebound effect. The act of avoiding traumatic memories given their aversive qualities, the more they intensify in the form of reexperiencing symptoms,

particularly intrusive memories, flashbacks and nightmares.

Have an overgeneralized memory (scattered and lacking coherence) and recall style which intensifies hopelessness and impairs problem-solving. Difficulty remembering specific positive experiences. Memories are fragmented, sensory-driven and fail to integrate traumatic events into autobiographical memory or narrative. Let the traumatic events define who you are.

Engage in thinking traps. For example, tunnel vision as evident in the failure to believe anything positive could result from trauma experience; confirmatory bias as evident in the failure to retrieve anything positive about one's self-identity; or recall any positive coping memories of what one did to survive, or what one is still able to accomplish in spite of victimization; do mind-reading, overgeneralizing, personalizing, jumping to conclusions, catastrophizing; sweating the small stuff and emotional reasoning such as viewing failures and lapses as endpoints.

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

At the Emotional Level

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

Magnify and intensify your fears and anger.

Experience guilt (hindsight bias or Monday quarterbacking), shame, complicated grief, demoralization, loss of hope.

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

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

At the Behavioral Level

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

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

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

Engage in delay seeking behaviors. Avoid seeking help. Keep secrets, stuff feelings and be stubborn and rigid.

Engage in high risk-taking behaviors; chasing the "adrenaline rush" in an unsafe fashion.

Put self at risk for revictimization.

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

Engagement in self-handicapping behaviors ("excuse-making").

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

At the Social Level

Withdraw, isolate oneself, detach from others.

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

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

Have family members who are "enablers" and who protect you from exposure situations that can combat your avoidance behaviors and who make excuses for you, or who inadvertently, unwittingly, and perhaps unknowingly, reinforce your maladaptive behaviors.

Experience an unsupportive and indifferent social environment (i.e., individuals who are critical, intrusive, unsympathetic and who offer "moving on" statements such as "You will get over this. Time heals everything.")

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

At the Spiritual Level

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

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

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

Experience "moral injuries" that compromise values. Lose your "moral compass" and "shatter" your deeply held beliefs in safety, trust, self-worth; experience a "soul wound."

Avoid contact with religious members who can be supportive.

THE NATURE OF RESILIENCE

Such psychological processes as positive emotions, optimism, active coping, social supports and prosocial behaviors, meaning-making, humor, and exercise can foster and support resilience and reduce the intensity and duration of stress responsivity. Such positive activities are associated with reduced HPA axis reactivity. The impact of positive emotions is cumulative; repeated positive emotional experiences over time prime the system for optimal response to negative stimuli by expanding physical, psychological, intellectual and social resources (Fredrickson, 2001). There is a protective capacity of positivity. The presence of Oxytocin that accompanies engaging in resilience-engendering behaviors can counteract the impact of stress-engendering processes.

NEURO-PSYCHOLOGICAL MECHANISMS THAT NURTURE RESILIENCE

1. Reframing/Reappraisals is the ability to frame events in a relatively positive light. Functional MRI studies have shown increased activation in the lateral and medial prefrontal cortex regions and decreased amygdala activation during reappraisal. The increased activation in the lateral prefrontal cortex (the "executive" center) helps modulate the intensity of emotional responses and keeps the amygdala in check. Resilient individuals are better able to extinguish and contextualize traumatic emotional memories and can more readily retrieve positive memories.

2. Use of Humor is a way to engage in cognitive reappraisal and emotion regulation. A network of subcortical regions that constitute core elements of the dopaminergic reward system are activated during humor.

3. Exercise, Meditation, Mindfulness and Acceptance type activities have both neurological and psycho-social benefits and bolster resilience.

4. Optimism is the inclination to adapt the most hopeful interpretation of the events which influences emotion regulation, contributes to life satisfaction, and increases psychological and physical health. An optimistic future-oriented outlook has been associated with increased activity in the amygdala and anterior cingulated cortex. For instance, optimists have lower rates of dying after cardiovascular disease over 15 years, compared to pessimists.

   As Southwick and Charney (2012, p. 25) observe, "optimism serves as the fuel that ignites resilience and provides energy to power the other resilience factors". But it is realistic optimism that works best, whereby individuals pay close attention to negative information, and not blind optimism that does not work.

5. Active goal-directed problem focused coping of taking direct actions when stressful life events are potentially changeable can increase neurotransmission in the mesolimbic dopaminergic pathways that increase pleasurable feelings and that stimulate reward

centers such as the ventral striatum. Dopamine release in the brain leads to "openness to experience", exploratory behaviors, and to the search for alternatives. A form of active coping is to engage in Behavioral Activation (physical exercise) which has positive effects on mood such as depression and that promotes resilience and neurogenesis. Exercise increases the level of serotonin, norepinephrine, dopamine and by stimulating the reward circuits in the brain. Exercise has also been shown to increase the size of the hippocampus and serum levels and increase brain volume (prefrontal cortex), especially among the elderly.

In some instances, when stressful events are <u>not</u> changeable, the use of emotional-palliative coping strategies such as acceptance, distraction, spirituality are the best ways to cope.

INTERVENTION STRATEGIES THAT BOLSTER RESILIENCE

(See Meichenbaum's Roadmap to Resilience book for examples roadmaptoresilience.wordpress.com)

- Use Physical exercise - - Behavioral Activation and use Active Coping Strategies.
- Use Emotional Regulation and Distress Tolerance Skills and Increase the Protective Capacity of Positivity that Buffers Negative Feelings.
- Focus and savor positive emotions and past reminiscence and anticipate positive emotions (anticipating). Engage in goal setting and affective forecasting in the form of positive future-oriented imagery that nurtures hope. Avoid "dampening" or minimizing positive events ("*I don't deserve this*." "*This won't last"*).
- Engage in Mindfulness Exercises - - pay attention in a particular way, on purpose in the present moment, and nonjudgmentally.
- Engage in Loving-kindness Meditation and engage in Acts of Kindness.
- Engage in gratitude exercises ("Give back and pay forward").
- Engage in Forgiveness exercises Toward others and Toward One-self - - Compassion is the awareness of the suffering of others and oneself, coupled with the wish and effort to alleviate it.
- Engage in Meaning-making Activities and Cognitively Reappraisal ("Healing through meaning")
- Use Spiritual-related Activities- - Use of One's Faith and engage in communal religious activities (See Meichenbaum "Trauma, spirituality and recovery" on Melissa Institute Website)

- Increase Social Supports - - keep interpersonally fit by participating in positive activities; selectively choosing and altering situations, improving self-presentation (smiling, dressing up), improving communication skills and accessing social networks.

- Use HUMOR, but as a therapist do so JUDICIOUSLY and STRATEGICALLY. Do NOT
  use humor too early in therapy before you have established a therapeutic alliance. Doing so may be misinterpreted as the therapist not appreciating the depths of the patient's emotional paint and losses.

- The patient may offer "Gallows' Humor" and the patient using such humor may reflect an adaptive expression of resilience, that has beneficial effects on the neurotransmitters of the brain (triggers endorphins and reduces stress hormones).

- REMEMBER that smiling also has positive feedback on the brain. THE NEXT TIME YOU TAKE A SELFIE, NO MATTER WHAT YOU MAY BE EXPERIENCING OR FEELING ----- SMILE!

- Help patients build and broaden positive emotions. The impact of positive emotions is cumulative.

- Repeated positive emotional experiences over time, prime the body for optimal response to negative stimuli by expanding physical, psychological, intellectual and social resources. There is a protective capacity of positivity. The experience of positive emotions such as realistic optimism, joy, pride. commitment, awe, forgiveness, gratitude and compassion toward others or toward oneself have been associated with distinct neurological and psychological changes. These positive emotions reduce physiological arousal and enlarge the focus of attention, allowing for more creative, inclusive, flexible integrative perspective taking, engenders positive reappraisal of difficult situations, fosters problem-solving coping and facilitates the infusion of ordinary events with meaning.

- Encourage patients to engage in OPPOSITE ACTIONS AND FEELINGS. Encourage them to develop and implement BUCKET LIST activities.

- Each of these Activities will help <u>bolster resilience</u> by increasing the accompanying neurobiological processes. There is increasing data that a course of psychotherapy- even without medication- had measurable physical consequences in the brain.

Phases of Stress-inoculation Training

Phase I - - Conceptualization and Psychoeducation

Establish, maintain and monitor the therapeutic alliance using ongoing session-by-session patient-informed feedback.

Establish a warm, nonjudgmental, respectful, trust-engendering treatment environment. Be sensitive to ethnic and racial differences.

Assess for prior history of victimization, intergeneration transmission of trauma, address safety issues from the outset and throughout treatment (e.g., suicidal behaviors, possible, revictimization, engaging in high-risk behaviors).

Use a Case Conceptualization Model of risk and protective factors. Tap the patient's implicit theory of presenting problem and treatment needs.

Address any potential therapy-interfering behaviors and patient concerns around "stigma" and barriers to treatment engagement such as compensation and entitlement issues that can act as interfering "secondary gains."

Use Motivational Interviewing and Collaborative goal-setting procedures. Establish SMART treatment goals.

Conduct psycho-education in a non-didactic fashion about the nature of PTSD and treatment.

Use Timelines to solicit patient "strengths" in the past and present, namely, "in spite of" activities and achievements. Pull for the "rest of the story" and influence the relative retrievability of different positive memories. Journaling and writing can enhance adjustment.

Conduct psycho-education about how positive emotions and activities can change brain structure and function. Highlight ways to bolster patient resilience. Prepare the patient for Phases II and III of SIT.

Normalize symptoms and prioritize and address any presenting symptoms and maladaptive behaviors (e.g., sleep disturbance, avoidance behaviors, "victim" mindset).

Phase II: Skills Acquisition and Rehearsal

Begin with a discussion of how patients inadvertently, unwittingly, and perhaps unknowingly contribute to and can exacerbate their presenting problems. Use a CLOCK metaphor to help the patients appreciate the interconnections between their feelings, thoughts and behaviors - - a self-sustaining "vicious cycle."

a. 12 o'clock - - appraisal of external and internal triggers
b. 3 o'clock - - primary and secondary feelings
c. 6 o'clock - - automatic thoughts, thinking style and developmental schemas and beliefs
d. 9 o'clock - - behaviors and reactions from others

Help the patient appreciate ways they can "break the cycle" by using intra- and interpersonal coping skills.

Teach emotion-regulation, cognitive reframing and active behavioral coping skills.

Do <u>not</u> "train and hope" for generalization and maintenance of coping skills, built into treatment generalization guidelines (See Meichenbaum, 2017).

Tailor interventions to the dominant emotional needs of the patient (fear, anxiety, guilt, shame, anger, grief, moral injuries) and provide integrated treatments for presence of any co-occurring disorders such as PTSD and substance abuse. Where indicated, imaginal dialogue (Gestalt empty-chair procedures), where indicated.

Incorporate, when indicated the patient's faith, religion and spirituality. Help the patient make a "gift" of trauma experience and undertake meaning-making activities.

Phase III: Application, Relapse Prevention and Follow-through

Challenge, cajole and encourage the patients to practice coping skills <u>both</u> in session (imaginal rehearsal, role playing), and in vivo settings identified by means of a planful graduating ("inoculating") hierarchal fashion.

Ensure that patients "take credit" for behavioral changes. Nurture a personal agency self-attributional style of mastery of stress.

Focus on psychosocial rehabilitation and on improving social relationships, social reintegration vocational/educational functioning, and daily routine and leisure activities. Help patients reengage life.

Use Relapse Prevention procedures and follow-through interventions such as ongoing coaching, booster sessions and involvement of significant others in treatment.

Throughout all Phases of SIT solicit patient-informal feedback on a session-by-session basis, and adjust treatment accordingly.

Resources on Stress Inoculation Training (SIT) and Related Interventions

1. Google Stress Inoculation Training to read various Websites and papers that describe SIT. Also, see video application of SIT in training military personnel.

2. Visit www.roadmaptoresilience.com for a description of ways to bolster resilience and www.melissainstitute,org for follow-up articles including treatment manuals on Prolong and Complicated Grief, Ways to integrate spirituality and psychotherapy, and ways to bolster resilience in LGBTQ youth.

3. Monson & Schreiler (2014, pp. 89-90) and Meichenbaum (2007, pp. 501-507) provide procedural guidelines. Meichenbaum (1985) SIT Elmsford, NY: Pergamon Press provides the initial description.

4. Smith, R.E. & Ascough, J.C. (2016) Promoting emotional resilience: Cognitive-affective stress management training. New York: Guilford Press overlaps with SIT.

5. Meichenbaum conducts workshops on SIT (dhmeich@aol.com).

TABLE 1

Examples of Anger Management Skills

Learn about what triggers your anger. What do these various situations have in common?

Learn the cues, warning signs, "red flags" that your anger is building or that you might be losing control.

Develop an anger-control plan. "If ...then" rules. Both immediate coping strategies and preventive strategies.

Monitor your anger using a 1 to 10 scale, where 10 is when you lose control and experience negative consequences.

Keep a journal of your anger episodes. Analyze anger episodes using the Clock model. (Triggers, emotions, thoughts, and behaviors). Ask yourself what you have done to make the "anger cycle" worse? Figure out what you can do to break the "anger cycle".

Change hostile attitudes.

Question and challenge your self-talk that makes anger worse.

Lower your arousal level and regulate emotions by using breathing and relaxation exercises.

Blow off steam through physical exercise.

Distract yourself with positive activities.

Take a "time out" or "cool down" . Remove yourself from a provocative situation.

View the provocation as a problem-to-be-solved, rather than as a personal threat.

Talk to a friend about what is angering you.

Imagine how a friend or relative who does <u>not</u> get angry would handle this situation.

Act assertively (not aggressively) by standing up for your rights, but in a respectful way. Use "I" statements-- "I feel X, in situation Y, when you do Z.", instead of "You" accusatory statements.

Use your Toolbox of coping strategies.

Remind yourself that being angry will most often <u>not</u> help you achieve your goals and it may harm important relationships.

Remind yourself that anger also hurts your physical health.

Remind yourself that there is a price you pay for ruminating and carrying a grudge.

Remind yourself that there is nothing wrong with being angry. It is what you do with that anger that is critical.

LINK TO ANGER MANAGEMENT AND BYSTANDER INTERVENTION COURSE

https://melissainstitute.org/wp-content/uploads/2020/11/Powerpoint-First-Half1-1.pdf

WAYS INDIVIDUALS, COLLEAGUES AND ORGANZIATIONS CAN BOLSTER RESILIENCE

The research literature on resilience indicates that a multi-prong intervention approach needs to be implemented, namely:

1. What can be done at the INDIVDUAL level in terms of helping hospital staff attend to their needs.

2. What can be done at the COLLEGIAL level in terms of social supports

3. What can be done at the ORGANIZATIONAL level in terms of providing on an ongoing basis the practical and leadership supports.

Each of these levels of interventions need to be a " bottom up " approach with suggestions and evaluations coming from the staff.

The following List of RESILIENCE-ENGENDERING COPING STRATEGIES enumerate various ways to provide assistance to hospital staff Also, for additional coping strategies, visit the Website roadmaptoresilience.wordpress.com.

INDIVIDUAL LEVEL

- Create A Formalized Way To Shift As You Leave Work: An Intentional Way Of Leaving Work At Work To Engage In Your Personal Life.
    - Walk
    - Listen to a specific song
    - Taking a deep breath or two or ten as you leave. Envision breathing in _____ (peace/happiness/serenity etc.) and breathing out _____ (stress/anxiety/COVID etc.)
    - Ceremonial changing of shoes/clothes envisioning leaving your work with what you change out of
    - Visualization or conscious thought as you leave: building/parking lot, that you are leaving work at work. Look in your rear-view mirror and see it behind you.
    - Write down the stresses you are leaving and put them in a box/envelop/folder that you literally leave at work to be picked up when you return.

- Replenish with physical and mental well-being activities and allow yourself to escape
    - Exercise or outdoor activities
    - Create a sleep routine including healthy daytime rhythms: Refer to "Roadmap to Resilience" in Appendix A for How To: Improve Sleep Behavior
    - Outdoor patios/backyards/parks
    - Cherish and foster connections, friendships and family
      Reach out to them: virtually through interactive video calls etc. to talk, or do an activity while on the virtual call such as watch the same movie or a walk, electronically with email, text, message or comments on social media, write an actual letter and mail it: a letter to say hi, or a Thank You letter

- Maintain Healthy Life Balance, Allow Yourself To Recharge
    - Outlets and interests beyond work such as hobbies and social activities
        - Activities that have a concrete outcome to foster a sense of accomplishment:
            - Learn a language, instrument, or new skill
            - Volunteer work, write letters to nursing homes etc
        - Activities that allow you to create and express feelings
            - Garden, paint, dance, writing: poetry or journaling
            - Journaling
                - Writing your feelings to get them out, in a journal
                - Write a letter to someone or about something you're upset or stressed about. Get all the feelings out in that letter and then destroy it. (tear it in to tiny pieces, burn it, wrinkle it up, and throw it away *Any combo of the three)

- Recognize You Are Not Alone – **Repeat "I Am Not Alone"**
    - Consciously pause, think about that phrase. Remember those words when you're overwhelmed, before work, before you go home – *Anytime you forget*

- If you forget. Reach out to a colleague or someone else in healthcare who understands the stresses. You can even create a "disaster plan" to have a sponsor where if you get in a dark place and feel alone, you both know you might reach out to say, I'm feeling alone or have a code word or phrase. To hear them respond with, I feel you/I get it/I'm here – will remind you.

"I recognize that others are going through this as well."

- <u>Develop And Cultivate A Philosophical Acceptance Outlook</u>

The Serenity Prayer
"God grant me the serenity to accept the things I cannot change, the courage to change things I can, and the wisdom to know the difference."

- Appreciate the positives
  - Commit to find one positive in each day. Create a list/collection of sticky notes, write them in a book. Have a physical copy, that you can look back on and see your progress and also to see there is hope when you can't think of a positive during a dark moment.
- Acknowledge and accept things that can and cannot be changed
  - Create a "To Do" list, of things that can be changed
  - Create a "To Let Be" or "To Accept" list – to help you acknowledge things you can and cannot change. Once you acknowledge, you can remind yourself they are things you cannot change. Identifying and reminding yourself, is an actionable step you can take towards acceptance.
- Work on things you have the ability to change
  - Create a To Do List, of things you can change.
    - For each item in the list, create steps of what you can do.
    - For some of the items, create deadlines. Accomplishing goals gives you a sense of achievement.
- Take pride in and recognize the privilege in being in a helping profession, especially in the setting of the stress of a pandemic
  - With co-workers, with patients, with family: You are all interacting in a vulnerable space. Look for the magic and privilege. Start a list of things you find in each day. Find one thing in each day. (Invite coworkers to add to the list as well. Have it be visible in a common area.)
- At work, remind yourself in the moments of interactions with your patients/colleagues/visitors; you are in the helping position that allows you to, during their time of vulnerability, make a difference with simple kindnesses per your interactions of their visit/day.

"The name of the game is IMPROVISE, ADAPT, OVERCOME. Be flexible by necessity. Take one day at a time!"

- Spiritual Coping Strategies
    - Active involvement in a religion, online/TV services, service measures to donate time/clothing/items of need, checking in on or meals for elderly neighbors
    - Each day converse or have a connection with your higher power, out loud on your way to or from work, in the form of a prayer, symbolistic jewelry/emblems as a reminder you are watched over, express gratitude, find purpose
    - ***"I do Nature Therapy daily. Go for walks- review my nature videos and pictures. Appreciate the awe of nature."***
    - ***"I find strength in being altruistic – a higher purpose in life."***
    - ***"This pandemic is God's way of testing us. I will meet this challenge and become stronger."***
    - ***"When I drive home, I am constantly talking to myself and to a higher power. I keep asking questions for which there are no answers."***
    - Refer to "Roadmap to Resilience" in Appendix A for Spiritual Fitness Coping Strategies

PEER/COLLEGIAL LEVEL

- Assess Your Social Support

"I rely on my "battle-buddy" – my fellow worker who keeps tabs on me and for whom I do the same for him/her. We check on each other frequently at work and at home."

    - Create an actual list of who would/could be emotional, informational, and or material support? (Might be different people for each type)
        - Identify: family, friends, coworkers who are helpful. In what ways are they helpful?
        - Create a game plan, whether talking to them or having the list and knowing those are people you feel you could go to in those moments
    - Actively/intentionally maintain connections with peers and colleagues.
        - Set a goal. I will reach out to ____ # peer/colleague/friend each day. Can be verbal if you see them or a form of communication of your choice. Personalize the communication. Instead of just, "how are you?" "How are you doing with the pandemic/pandemic stress?" "How's your family/cat/dog/kids/job/ holding up during all of this?" "How are you kids doing in school?" "What have you been doing to keep active/healthy/happy/_____?" "Good job on _____ with that patient/staff/patient family etc. I think the way you (helped them calm down, helped them feel safe, taught them about _____) worked out well"
    - Ask yourself: Do I have the strategies, abilities, confidence and desire to cope with unhealthy, harmful relationships? If not, what can I do to protect myself? How can I learn, or who can I learn from?"

"There is no shame for asking for help. No one can do this alone. I realize I am not the only one with these problems. You do not have to try and do it yourself."

    - Can you identify a mission, cause, group of family or friends that you can engage with that will give purpose?
    - Can you identify individuals who value joy, improving the situation and who seek productive meaning-making?

        - Community coping efforts or support that generate a sense of hope, trust, solidarity, and connectedness
            - Public rituals, prayer circles, memorials, demonstrations, artistic expressive activities, theatre performances, reconciliation meetings, religious services, live music
    - Can you identify a role model or mentor?
        - What behaviors, actions or attributes do they have that caught your attention as someone to be a role model or mentor?
        - What behaviors do they have that stand out during these stressful times?
            - Can you ask them how they learned the behavior(s) that stands out to you?
        - What behaviors do you have, that are similar to theirs
        - What behaviors do you have, that would be helpful to change so you could develop behaviors similar to theirs?

    "I nurture and invest in social relationships. I try to be useful to others. I can text, email, call, Skype, join Internet exercise and yoga classes and chat lines on the Internet, use Zoom, watch Netflix movies with others, schmooze on the phone in order to lift the dreadful cloud of COVID-19 for a little time. You have to 'give in order to get'."

ORGANIZATIONAL LEVEL

- Regular Or Semi-Regular Team Meetings As A Form Of "Emotional Check-Up"
    - We don't need to fix or solve the problems of their stress, but employees need to know we care. The simple act of stating that or phrasing it "We know we can't fix the fact that we are in a pandemic right now and things have continuously been incredibly stressful. What we can do is create venues/opportunities for you to talk and be heard – on various levels." * coworkers, managers, EAP have various parts ***"People in deep grief (stress/trauma) 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...".***

- Training/Educational Opportunities To Learn About Resilience, Burnout, Wellness
    - Bring the interventions to staff (especially initially, in crisis/survival mode, they likely don't have the mindset to begin, to seek out or know what they need or what would help)
        - Arrange for EAP to visit the units/departments
        - Workshops on building resilience to learn which: actions, behaviors and thoughts improve or hinder resilience
        - Create a campaign to initiate awareness for the concern for the resilience of staff

    "… 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".

- Community/Team Building Initiatives

- Ongoing Supervision, Checking In On Staff
  "We have end-of-shift 'campfires' – a kind of debriefing where we can give voice to our experiences, vent and problem solve. We have created a kind of social support group."

- Create And Ensure A Psychologically Healthy Workplace In A Way That Is Actionable And Visible And Ongoing
  - Psychological health includes the need people have for feeling connectedness and sensing belonging

TREATMENT OF ANGRY YOUTH: INTERVIEWING PROCEDURES TO HELP THEM BECOME RESPONSIBLE PROBLEM-SOLVERS

(See Larson, 2005 THINK FIRST Program and view a You Tube that demonstrates the interviewing procedure)

https:// www.youtube.com/watch?V=Lkz2Cgw0wic

The interview procedure has three phases: Preparation, Problem-solving and Implementation.

PREPARATION PHASE

- Focus on establishing a collaborative alliance through active listening, empathy and reframing
- Help de-escalate intense feelings
-Solicit the youth's view of the problem through developing a timeline

> "What happened before, during and after the anger incident?
> What did the youth and others do and say?
> How does the youth feel about what happened? "

- Review the story in highlights, emphasizing strengths and coping skills
- Nurture hopefulness and collaboration with positive "we" statements

PROBLEM-SOLVING PHASE

- Help the youth take the perspective of others.

> "Why do you think he/she said that?
> Could he/she have been thinking that you were....?
> How do you think he/she feels about what happened? "

- Help the youth generate as many alternative solutions as possible.
- Nurture a GOAL, PLAN, DO, CHECK approach.
- Help the youth identify both internal and external triggers to his/her anger.
- Use a CLOCK metaphor to have the youth better appreciate the interconnections between the ways he/she appraises internal and external events (12 O'clock), their accompanying feelings (3 O'clock), their thoughts (6 O'clock), and their behaviors and the reactions of others (9 O'clock).

IMPLEMENTATION PHASE

- Convey to the youth that this behavior change is a "challenge", bolster the youth's self - confidence.

> "It won't be easy to do what we have been talking about
> Maybe it is too early to ask you to do.....
> This is going to take courage and street smarts. How will you begin?"

-Help the youth select an action plan to try and walk him/her through, both behaviorally and use imagery rehearsal.

> "What will you have to watch out for?
> What will you do when...? "

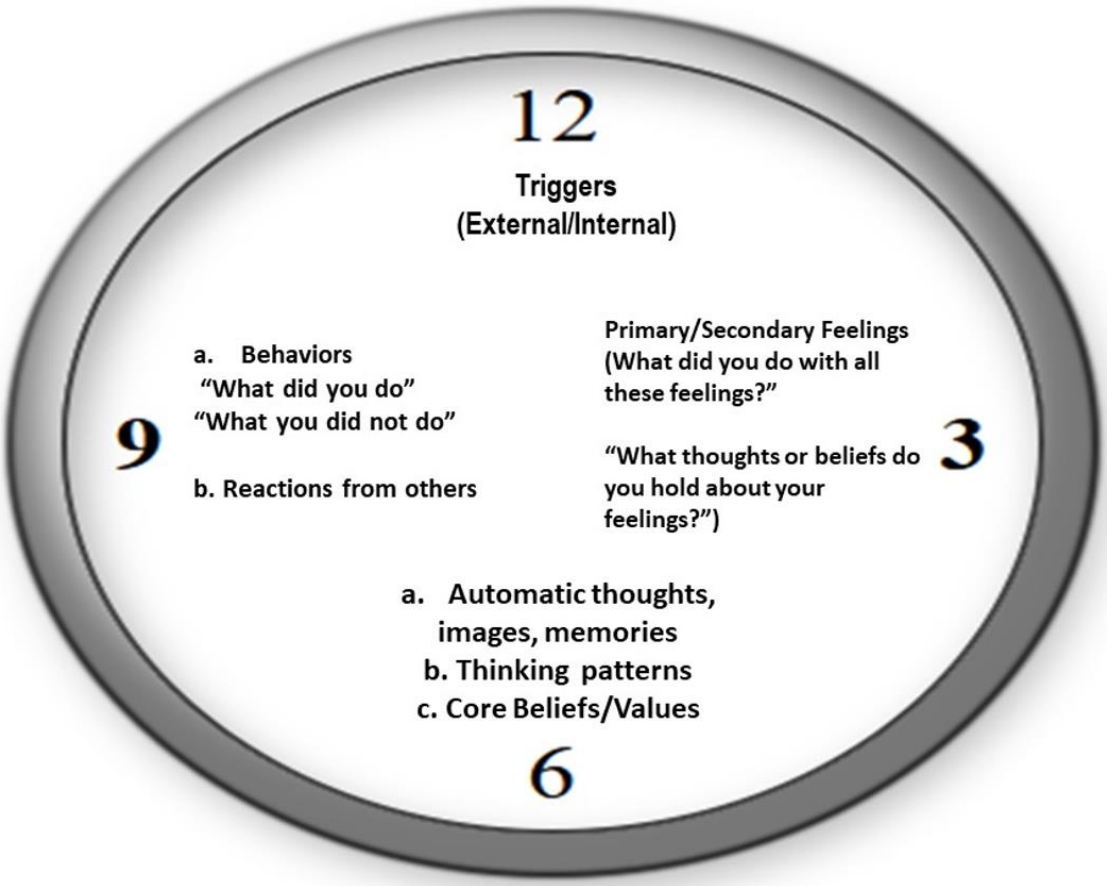
- Practice the action plan with the youth.

- Reinforce effort.

> "I am impressed with your maturity and willingness to try a new way of handling.....
> I give you a lot of credit for being able to (use meta cognitive verbs such as notice, Catch, interrupt, plan, make smart choices, and so forth) Give specific examples and ask the youth whether he/she agrees?

- Encourage the youth to explain how he/she will benefit from the new behaviors

These interventions can also be used on a group basis.


12
Triggers
(External/Internal)
9
a. Behaviors
"What did you do"
"What you did not do"
b. Reactions from others
Primary/Secondary Feelings
(What did you do with all these feelings?"
"What thoughts or beliefs do you hold about your feelings?")
3
a. Automatic thoughts, images, memories
b. Thinking patterns
c. Core Beliefs/Values
6