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The Importance of Mindfulness, Exercise and Social Connection in Supporting Resiliency

An Interview with Steven M. Southwick, MD

Steven M. Southwick, MD, is affiliated with the US Department of Veterans Affairs National Center for Post-Traumatic Stress Disorder (PTSD) Clinical Neurosciences Division at the VA Connecticut Healthcare System in West Haven, CT 06516 and the Department of Psychiatry, Yale University School of Medicine in New Haven, CT 06510. Dr. Southwick is a renowned expert in resiliency and co-author of the book: *Resilience: The Science of Mastering Life's Greatest Challenges*, (Charney, Southwick, 2012). In 2015, Dr. Southwick's co-authored article: Resilience: An Update, (Southwick, Pietrzak, Tsai and Krystal, 2015) was published in the PTSD Research Quarterly, (a publication of the National Center for PTSD, United States Department of Veterans Affairs Veterans Administration Medical Center).

Q: In your publications you outline and discuss resiliency enhancing interventions, one being mindfulness and meditative practice. How does this help create resiliency?

A: I think mindfulness is a very powerful and important skill that can be learned. Mindfulness is basically learning the ability to stay in the present moment. The way that meditation practice works is I may focus on one thing like my breath during a 20 minute time frame. Of course my mind begins to wander after about 15 seconds. With practice, I learn over time to more and more rapidly, recognize self-awareness, recognize that my mind has wandered and then gently if you will, remind myself to focus on my breathing and to not judge the fact that my mind has wandered. So why would you do this, who cares? Well, our minds are wandering all the time. It's called monkey mind, and actually that state of mind wandering has been associated with lower levels of happiness. It's sort of an unpleasant state. Usually, that kind of mind wandering is about ourselves, it's pretty self-referential and what happens when our mind wanders is that we ruminate and anticipate. Other animals don't do that in the same way that we do. The problem with all of that is you can activate your stress response 24/7 which is bad for you. What we have found out, is that when you practice attending to one thing – 100% attention on say, just one breath, it enhances your capacity for self-awareness and changes your brain circuits. This is like exercising a muscle, you get better and better at it. So why do I care that I can attend to something 100%? Because during your normal life you can more easily come back to the present moment, because that's the only moment you have. The rest is who knows. The things you worry about may never happen. Mindfulness allows you to reframe experiences. You don't judge them in the same way and you then change the way you judge things and situations.

Richard J. Davidson, Ph.D., and others have shown that people that have been meditating for a long period of time tend to have greater activity in the pre-frontal cortex and reduced activity in the amygdala so there is more pre-frontal cortical inhibition. Optimism and well-being have been associated with increased activity in the left pre-frontal cortex.

Davidson has shown that individuals that meditate have a greater tendency for left pre-frontal activity. Mindfulness as a practice has been around for centuries and centuries. Many spiritual traditions have some kind of mindfulness - even rosary beads and mantras are forms of mindfulness because you are focusing on just one thing.

An important component of mindfulness is exposure. At the heart of anxiety disorders is avoidance. You avoid reminders, which is perfectly natural, we all do this. The problem is you can never really extinguish fear. Practicing mindfulness, if you think about it, has you going toward whatever emotion your feeling. If I'm feeling fear, I don't avoid it, I do the opposite. I actually observe it and try not to judge it. Zen Master Thich Nhat Hanh, the Vietnamese Buddhist monk might say something like: "*Hello fear, I know you, I am going to welcome you and I am going to embrace you. I am going to take care of you as a mother takes care of a child."* There is huge animal literature on extinction and fear conditioned memories. What you learn, is that extinction is most likely the formation of new memories and the new memory is "I am safe being with this memory." It's very stressful at first but you keep saying it over and over with the therapist and you learn nothing bad happens. You are learning a new association with this traumatic memory that it's safe. That new memory now competes with the memory that is still there.

Q: So mindfulness helps decrease cognitive distortion?

A: It absolutely helps with that. There are certain cognitive factors that affect resilience. One is the ability to accept what you cannot change. Resilient people are generally very good at this. There's an acceptance, so in mindfulness you are learning not to judge. As we know there is a constant stream of chatter. We think we initiate this chatter. It's partly because of the way the brain is constructed. We process information through an associative learning pattern. Different pieces of an experience are pulled together and synthesized in a memory. I may go outside, I see a grey car, the grey car reminds me of my bosses grey car, which reminds me of an argument I had with my boss. Now I'm having an internal argument with my boss which reminds me of someone else I had an argument with. Now I'm having an internal argument with them. I believe I initiated those, I didn't initiate those. I saw the grey car, that's how the brain works.

Q: It seems that these associations we make also serve to protect us.

A: Yes, if I see something terrible that happened on a hot and muggy day at sunset in February, those all become part of the memory. Those become predictors of a possible future danger. That's why people have anniversary reactions. This is happening in the limbic system, below the cortex. I am not aware this is happening. This is self-preservation. It just so happens we learn largely by associative learning. A big part of mindfulness is related to freedom. I become an observer, the watcher of the thinker. I am now watching and not responding to every single emotion and thought. I am learning to watch thoughts as if they are clouds going by. People ask: "Is this going to make me more emotionally distant from life?" Well it's actually the opposite, because now you are not being run around by every single emotion and thought. You have a greater ability to choose what you might want to attend to and what you would like to focus on. Your emotions aren't any less, but now you can choose and have more control.

What causes PTSD is uncontrollable stress. Stress that an individual believes they can't manage. Child abuse for example, or a soldier in a fox hole and mortar rounds are going off where the soldier can't determine where it's going to land…that's uncontrollable stress in big quantities that tends to be toxic to the nervous system. For children, actually everyone, too little stress and you may see atrophy, it's called 'use dependent neuroplasticity'. A great parent, mentor, teacher, coach knows their child, pupil or mentee well enough to understand what is out of their comfort zone but not overwhelming so they get the right amount of stress for growth. There are many animal studies that show that your cortisol system and adrenaline system can be influenced dramatically by the way you are raised. There is a term called the "good enough mother". A good enough mother is the best mother or a good enough father is the best father. They don't neglect or over-parent, rather they allow their children to have appropriate challenges for growth.

Q: Aside from mindfulness, what other behaviors are significant influences on resiliency?

A: I am a big believer in exercise. There are studies that show that exercise is good for mild to moderate anxiety and depression and in some clinical trials, as effective as anti-depressants. It's a little early to say definitively but, there is a lot of good evidence that exercise is good for your mood and good for cognition to keep your brain healthy. Exercise is associated with increased oxygenation, serotonin and neurotrophic factors. The great thing about mindfulness and meditation is that most people can do both of these things. There is a good study that took 70 year olds and had ½ the group exercise just 3 times weekly versus a group that was stretching and toning 3 times a week for a year. They measured the size of the hippocampus before and after one year of this moderate exercise versus stretching. Those who did the exercise had a 2% increase in the size of their hippocampus. The other group had a 1.4% decrease in the size of their hippocampus. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041121/). Spatial memory was improved as well. By the way, this was not an extreme exercise regimen. There are numerous fascinating studies on exercise and longevity.

In addition to mindfulness and exercise, resilience is very much enhanced by positive healthy social interactions. There are many reasons for that, some of them are biological. When I am with people in a dangerous or challenging situation, my stress response is better modulated than if I am by myself. I also tend to use better coping mechanisms when I am with people I really care about. For example, I tend to be more of an active coper, because I know people have my back. My positive self-esteem tends to be better and so forth. Social support is huge, it's as important as those other mindfulness/meditation practices and exercises, maybe even more important.

If I had to choose just one intervention to support resiliency, I would suggest that individuals find a group, social support or peer support. A good example is the Veteran's Administration's Errera Center in West Haven, CT. The problem is if you are depressed and suffering with PTSD, you may not be able to either meditate or exercise on your own. The Buddhists talk about having a Sangha (community) to support mindfulness practice. The average person goes to a mindfulness course and may practice for a few months, but then their practice ends. The nice part about making the connections, is that in and of itself, it is resiliency enhancing. This makes it more likely individuals will

participate in social behaviors and potentially engage in mindfulness and exercise.

Another big part of resiliency according to Bruce McEwen, PhD., professor of neuroscience at Rockefeller University and others, is learning how to recover. One of the measures of good cardio fitness is that you activate various hormones and blood pressure, heart rate etc. When you stop exercising, those measures come back to baseline rapidly. What Bruce McEwen, Ph.D., and others would say, is that, I have to know how to bring my stress response back to baseline quickly. In the book *Why Zebras Don't Get Ulcers*, (Robert M. Sapolsky, 2004) the author describes how the zebra when chased by the lion, has a big stress response, but as soon as it is safe, it's stress response returns to normal. Humans have this big pre-frontal cortex and so we ruminate and anticipate, we think, *"Oh my gosh, I could have been eaten, what if it happens again?"* We have a hard time bringing our stress response down to baseline. That's not very good for us, particularly because it's wear and tear on our bodies and minds and effects our quality of life. A big part of being resilient is bringing our stress response back to baseline through mindfulness or whatever method works for the individual. Adequate sleep, nutrition and many other healthy habits additionally contribute to supporting resiliency and recovery from the stress response.

Q: Are there any cultural implications that are related to resiliency that you think are significant?

A: Definitely. I think they are very significant because some cultures' are more collective, while others are more individualistic. Some eastern cultures are more collectively focused around family or community versus the individual. Our American culture is often reflective of the lone hero, although special-forces in the military don't think that way. For them, it's all about the collective team. Researchers often talk about how do we increase individual resilience? Well, some cultures wouldn't think of it quite that way. In fact, some of the most powerful interventions for resilience are undoubtedly not individual. As an example, the most important factor for a child is having a consistent caretaker that really loves you, cares for you, and presents appropriate challenges, etc. Healthy parenting is huge in fostering resiliency for children. An example of a collective approach might be supporting parenting classes, because parents may not know that some commonly utilized parenting techniques like helicopter parenting (www.merriam-webster.com/dictionary/helicopter%20parent) are not ideal for fostering resilience in children.

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Offense Related Trauma in Violent Offenders

By Brian Conover, Psy.D.

When we think of the history of trauma, and Post Traumatic Stress Disorder (PTSD), as a phenomenon and as a diagnostic entity, most often we think about the impact (physically, emotionally, and neurobiologically) of some horrific event or experience that is imposed on the trauma survivor by some external source. In part, one important aspect of trauma, and its impact on the survivor, is the perception (real or imagined) of the uncontrollable nature of the event or experience. Largely, this is the genesis of the fear and anxiety reactions that are so typical of many trauma related syndromes, and which (prior to DSM-V™) relegated PTSD, conceptually and diagnostically, to the category of anxiety disorders.

Copious research has consistently indicated the relationship between significant trauma experiences both as children and as adults and serious mental illness. (Mueser, K. et al, 2004 and Cusak, K. et al, 2006). Using a variety of measures of psychiatric symptoms, this body of research has indicated a positive relationship between previous experiences of abuse (physical, sexual, psychological) and neglect and the subsequent frequency, breadth, and severity of symptoms of major mental illness. In the fall 2013 edition of the Trauma Matters newsletter, Dr. M. Varanko highlighted a research article that quantified something that those of us working in the forensic psychiatry field know from our own experiences; that trauma histories are often relevant in the understanding and treatment of mentally ill offenders. Dr. Varanko cited Reavis et al (2013) who administered the ACE Questionnaire to 151 subjects who had been referred for outpatient mental health treatment following conviction in a criminal court. These authors found that offender groups reported nearly 4 times as many adverse childhood experiences as control samples.

Clearly, there is a profound fear and anxiety aspect to many trauma reactions, including PTSD. More recently, there has been increased attention, both in terms of research and clinical practice, to the roles (sometimes central) of other painful affect states. One of these affects is shame. In considering the potential role of shame in trauma related syndromes, it might be important to first differentiate between "shame" and "guilt", which are often used interchangeably, but are, in fact, two distinct experiences. Both shame and guilt can be understood as painful experiences associated with being negatively evaluated (by oneself or by others) in response to failing to meet some standard(s) regarding what is "good", "right", "appropriate", or "desirable" (H.B. Lewis, 1974). Some emotional researchers have distinguished between the two in terms of their origin and focus (Tangney, J. et al, 2007). In this manner, shame is understood to result from such moral failures that are attributed to the core or central aspects of the self, whereas, guilt is more tied to specific behavioral lapses. The difference being that suffers of shame see *themselves* as bad, flawed, or inadequate, and suffers of guilt view some of their *behavior(s)* as bad or amoral.

To those who work in forensic psychology, it will likely not come as a surprise that individuals who suffer from serious mental illness, and who have committed some violent offense can, and often do, suffer from trauma related syndromes in response

to their own offending behavior. On the face, this seems incongruous with our historical understanding of trauma. Traditionally, we have thought of PTSD as a consequence of some uncontrollable event (accident, natural disaster, victimization by another, sudden loss of a loved one), or to exposure to traumatic experiences in the "line of duty", such as with disaster workers, first responders, or combat soldiers. So how, then, do we understand trauma symptoms in reaction to one's own behavior, when the behavior is not "sanctioned" by society, as in the case of combat or first responders?

For most of those offenders who are in the mental health system, their acute psychiatric symptoms played a key role in the commission of their offense(s). To the degree that the offense was a product of psychiatric symptoms, the offender was not in complete "agency" of their behavior or their choices that led to the offense. In this manner, it may well be the experience of the offender that their crime was, in fact, an uncontrollable event, thus laying the ground work for the fear and anxiety components of PTSD. Unlike the survivors of physical abuse, emotional abuse, sexual abuse, or some other traumata that exist outside of the victim, for offenders, the very source of fear, anxiety, shame, and associated painful affects exists within them.

Further, for many mentally ill offenders, the act(s) they committed are so foreign to who they knew themselves to be as to be unimaginable. This leaves the offender with the struggle to process, understand, and integrate behaviors that are wholly inconsistent with their prior identity, and to wrangle with the prospect of future risk for offending. Part of this struggle may be complicated by the shame experience that can be a consequence of having committed such a horrific act, and one which was previously unimaginable to the offender. A number of researchers have explored the phenomenon of such "offense related trauma" and have found prevalence rates of 20%-50% (Pollock, P. 1999, Gray, et al, 2003, and Crisford, H., et al, 2008). Such findings have held fairly consistent across a number of well standardized and normed measures of PTSD, providing further support for the notion that one may be significantly traumatized by their own offending behaviors.

The presence of offense related post trauma symptoms in offenders can significantly complicate traditional offender treatment. Further, the symptoms are often not as apparent as those seen in PTSD in response to what we consider more "traditional" traumatic experiences. Anxiety, fear, anger, and depression are often readily observable and "make sense" in light of the trauma history. Shame based trauma symptoms, which appear more prevalent in offenders trigger a "hard-wired" response in which the shamed person attempts to hide, or be unseen by others. Whereas someone who is subjected to trauma from some external source may predictably engage in avoidance behavior of reminiscent triggers, that which the offender may avoid exists within him/herself, and includes a conscious awareness of those personal qualities that contributed to their offense. As such, on both an inter- and intrapersonal level, the traumatized offender is driven to hide awareness (his/her own and others') of their role in the offense, and that within them that contributed to it. This presents significant and unique challenges to therapy aimed at increasing one's sense of agency for their offense as well as addressing those factors which might contribute to future risk.

It is well known that the presence of PTSD can complicate the treatment of, and course of recovery from, co-existing major mental illness. This can occur through various mechanisms, including the impact of trauma on the therapeutic relationship, the role of trauma symptoms as a stressor that exacerbates other mental health symptoms, and the blurring of trauma symptoms with those of a major mood or thought disorder. To the degree that major psychiatric symptoms contribute to an offender's risk, unrecognized or untreated trauma symptoms may represent a significant contributor to current and future risk. Further, when shame is a significant aspect of the trauma reaction, the natural response to "hide" will complicate the offense-related work.

One might ask if offense related trauma symptoms should be addressed through treatment or if such symptoms may serve as a perpetual "reminder" to the offender and somehow act as a mitigating factor to future risk. From an ethical perspective, I would argue that, as mental health professionals, we have an obligation to attempt to resolve the suffering of those we serve, regardless of their offender status. Additionally, there exists no evidence that untreated trauma symptoms act in any way to mitigate risk. In fact, a convincing body of research and clinical data indicates the significant relationship between trauma and risk for violence.

In summary, I would suggest that those working with mentally ill offenders must be aware of, and acknowledge, the potential impact of offense related trauma in those they serve. Research suggests that the impact of trauma experiences may play a significant role in the treatment of mentally ill offenders, both as a contributor to one's offense(s) as well as a potential consequence of the offense. The effective and timely recognition and treatment of trauma symptoms, where they exist, should be a key aspect of treating those who have offended. Toward this end, such clinicians should actively consider and assess for potential underlying trauma symptoms early in the course of treatment. Effective treatment of these symptoms would facilitate the ongoing "offense specific" work, allow the offenders to begin to recognize and integrate those aspects of themselves that contributed to their offending behavior, and ultimately lead to a reduced risk for future offending.

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Ask the Experts: A Conversation with Carol Forgash, LCSW

By Cheryl Kenn, LCSW

Carol Forgash, LCSW is a psychotherapist specializing in the treatment of complex trauma and health problems of survivors of adverse childhood experiences (ACE). She is a past president of Trauma Recovery/EMDR Humanitarian Assistance Programs, a Facilitator for the EMDR Institute and an advanced Credit Provider for the EMDR International Association. She co-authored and edited with Margaret Copeley of *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy* which developed the integration of EMDR and ego state work in the treatment of complex trauma which has been translated into French and Italian. With Kathy Monahan, DSW,

she wrote a chapter in *Sexual Abuse - Breaking the Silence,* entitled: Childhood Sexual Abuse and Adult Physical and Dental Health Outcomes. She and Jim Knipe wrote *Integrating EMDR and ego state treatment for clients with trauma disorders,* which is published in the Journal of EMDR Practice and Research. For additional information about Carol Forgash, go to www.advancededucationalproductions.com

Q: Why did you enter the trauma field?

A: I was a young elementary school teacher in the 1960's in New York City. Many of my pupils had learning problems, but with extra assistance, they could and did succeed. I was able to use my creativity, musical skills and empathy to help them, however there were many children who were so traumatized. They would have been labeled 'disturbed' at that time, unreachable by me or their prior teachers. No trauma based curriculum existed to prepare teachers to aid these children in their struggles. I was able to get them free lunch, eyeglasses and dental care, but I couldn't help a child like Mary, who was eight years old when she found her mother dead from an overdose of heroin. In shock, she fell and hit her head, and developed a large red scar on her forehead. She also had a concussion and quite possibly a traumatic brain injury. Her grandmother, who was now raising her and her siblings, would frequently visit me and confide her worries concerning Mary's future. These were worries that I also shared. In school, Mary sat vacant eyed and mostly mute and unresponsive. Even with all the extra attention that I could provide, she could not learn, socialize or play.

During my short teaching career, although I loved working with the children, I felt totally ineffectual and in despair about all the "Mary's" in my classes. There was no help for them anywhere. My experiences with these children propelled me into a career as a clinical social worker. In graduate school (in the late70's), there was as yet, no instruction to prepare therapists to use trauma focused therapy. In the mental health clinic where I found employment, about 10% of the clients referred to me were incest survivors. Fortunately the movement to conceptualize and recognize post traumatic stress disorder was incubating. I was able to study the original and emerging masters of trauma and dissociation. My clients were patient teachers in helping me understand the terrible legacies of childhood trauma that persist in current life. Training in Ego State therapy, EMDR and the phased model of trauma therapy gave me a therapeutic basis for helping clients stabilize, effectively process trauma, resolve old issues and gain a fuller life. In an essay entitled "Hearts Broken Open", (David Brooks, New York Times. 6/19/2015), a respondent writes that in a time of trouble, someone helped him make positive changes and thus taught him to 'provide that whisper in someone's ear that changes their life." Trauma therapy provides the chance to whisper and teach the trauma survivor how to change their life.

Q: Can you tell us what you consider to be the most helpful stabilization skill or tool one can teach a trauma survivor?

A: In working with trauma survivors, particularly complex trauma survivors, I want to stress that the overarching umbrella of preparation /stabilization work is necessary to provide a beginning sense of connection, safety and sense of hope. The complex trauma survivor often comes into treatment with many layers of unresolved symptoms: Post Traumatic Stress Disorder (PTSD), dissociation, isolation, avoidance, and often no ability to trust. They frequently have the belief that their life is unmanageable. So, important skills would be those that help them manage life, especially outside of therapy sessions. These include getting to know their parts system, developing co-consciousness in the system, learning what conditions trigger flashbacks, and containment skills (2007).

I have found two skills particularly helpful and especially practical for clients. One is a self rating system called the Back of the Head Scale, developed by Jim Knipe, (2015) that allows the client to ascertain how "present" or how dissociated they are at any time. Over time, they rate themselves, practice a somatic, or grounding exercise, and find it easier to regain control. This also prepares them for trauma processing in the future. The other skill involves dealing with avoidance. Many survivors have difficulty with trauma related situations that involve dealing with performance and/or authorities. Examples include avoiding necessary medical appointments, paying taxes, taking examinations. If the client gains an understanding why various 'parts' get triggered by such events, they can metaphorically show the parts a safe 'home' in which to stay when the survivor needs to function as an adult. Rehearsal of this exercise, and the future event, allows the survivor to tend to present life more easily especially if they are not yet ready to process the traumas and other therapeutic issues. I refer to this skill as Constructive Avoidance. (Forgash, 2007).

Q: Can you tell us one thing or something you think all trauma-focused clinicians should know.

A: Jim Knipe and I have developed a Cross Training Model (2015) which includes EMDR (Eye movement, desensitization and reprocessing), (2001), Pierre Janet's three phase trauma model, dissociative disorder treatment models, ego state models, attachment models, somatic approaches, and the information regarding the traumatic legacy of ACE (Adverse childhood experiences. 1998) on physical and mental health. When a trauma therapist has a careful understanding and training in the therapeutic elements included in this model, I believe that they can then successfully address the problems of trauma survivors. At this time in the field of trauma informed therapy, there is an outstanding body of literature and curricula for reference and study of these models.

We believe that all trauma-focused clinicians should understand that it is essential to expand the stabilization phase of Janet's original formulation by weaving preparation skills through all three phases. The client may seem quite stabilized, but during the trauma processing and even resolution phases of work, they may be prone to losing the window of tolerance and then dissociate. Frequently they (and the parts system) need to be re-oriented to the present, practice, and rehearse the skills they learned earlier in the work. The trauma processing phase can be very triggering and the client can be easily overwhelmed and destabilized. It can test the therapeutic attachment. The client needs to be reinforced in their ability to do the work and in how much safety they have developed. They, with our guidance, need to return to the skills sets built during the stabilization phase whenever necessary. This is not a step backward, but an important lesson in the need to strengthen the foundation throughout the therapy.

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OF NOTE: Vermont leads the nation in proposing health care that screens for Adverse Childhood Experiences

Over the past decade, behavioral health systems in the United States have increasingly become educated about Adverse Childhood Experiences (ACE's) as evidenced in the Center for Disease Control and Prevention ACE Study (Felitti & Anda, 1998). Consequently, many community and state mental health systems are working to integrate trauma-focused programmatic and cultural changes that reflects the knowledge that ACE's can result in lifelong debilitating mental and physical health outcomes. While mental health care systems are making changes, the primary care medical community lags behind in basic awareness of the ACE Study and its significant health care findings. The good news is the tide is beginning to turn as more physicians learn about ACE's. As an example, Dr. George Till, a Vermont State legislator and physician, attended Vermont's first ever ACE Conference: *Improving Clinical Outcomes for Complex Patients* in October of 2013 where he heard Dr. Vincent Felitti, MD speak on the CDC's Adverse Childhood Experiences Study. In 2014 Dr. Till took action and proposed **Vermont House Bill H.762, The Adverse Childhood Experience Questionnaire** that calls for integrating screening for adverse childhood experiences in health services and additionally, integrating the science of ACE's into both medical and health school curricula and continuing education. This advocacy is noteworthy as it represents a significant change narrative in primary health care that supports and promotes integrative trauma-informed systems of care.

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