УДК 159.9.016.2

Pablo Polischuk

A METACOGNITIVE-DIALOGICAL MODEL TO CONCEPTUALIZE AND APPROACH PTSD

Сучасні підходи, які використовуються в лікуванні травм і ПТСР викладені і проаналізовані в статті. Їх ефективність та заслуги відзначені, що забезпечує основу для подальшого дослідження метакогнітивно-діалогічних можливостей у лікуванні.

Стаття є теоретичною моделлю, яка заснована та поширює концепції, що взяті з когнітивних і метакогнітівних моделей, застосовних до лікування травм і посттравматичного стресового розладу. Запропонована парадигма інтегрує психологічні та теологічні принципи. У статті наведений теоретичний аналіз метакогнітівного процесів, таких як контроль і регулювання внутрішніх діалогів, а також внутрішньої риторики адресації негативних стилів мислення при травмі та ПТСР. Ця перспектива може допомогти в направленні зусиль необхідних для використовування цілеспрямованих систем контролю, які можуть викликати надію та нормативний стиль реагування замість травматичних наслідків характерних для негативної реакції. Практика цих нових стилів метакогнітівного обробки, у тому числі релігійних вірувань і цінностей, може розвиватися і зміцнюватись, бо нові метанарративи знаходяться в онтологічній, структурній основі особистості. З точки зору такої вертикальної перспективи, людина може бути у змозі усвідомлено контролювати, регулювати, і цілеспрямовано вирішувати кращий курс дій. Практичні рекомендації та конкретні пропозиції до застосування пропонованої теоретичної моделі надаються.

Ключові слова:метапізнання; вертикальні систем виконавчого контролю; відокремлена повнота пізнання; цілеспрямована повнота пізнання; системи контролю зворотного зв'язку; контроль попередження; внутрішній діалог; внутрішня риторика; богословсько-психологічна інтеграція.

В статье изложены и проанализированы современные подходы, используемые в лечении травм и ПТСР. Их эффективность и замы-

ги отмечены, что обеспечивает основу для дальнейшего исследования метакогнитивные-диалогических возможностей в лечении.

Статья представляет собой теоретическую модель, которая основана и расширяет концепции, взятые из когнитивных и метакогнитивных моделей, применимых в лечении травм и посттравматического стрессового расстройства. Предложенная парадигма интегрирует психологические и теологические принципы. В статье приведен теоретический анализ метакогнитивного процессов, таких как контроль и регулирование внутренних диалогов, а также внутренней риторики адресации негативных стилей мышления при травме и ПТСР. Эта перспектива может помочь в направлении усилий необходимых для использования целенаправленных систем контроля, которые могут вызывать надежду и нормативный стиль реагирования, вместо травматических последствий характерных для негативной реакции. Практика этих новых стилей метакогнитивной обработки, в том числе религиозных верований и ценностей, может развиваться и укрепляться, так как новые метанарративы находятся в онтологической, структурной основе личности. С точки зрения такой вертикальной перспективы, человек может быть в состоянии осознанно контролировать, регулировать, и принимать улучшенный курс действий. Предоставляются практические рекомендации и конкретные предложения к применению предлагаемой теоретической модели.

Ключевые слова: *метапознания; вертикальные системы исполнительного контроля; отделённая полнота осознанно; целенаправленная полнота осознанно; системы контроля обратной связи; контроль предупреждение; внутренний диалог; внутренняя риторика; богословско-психологическая интеграция.*

Current approaches employed in the treatment of trauma and PTSD are outlined and analyzed in the article. Their efficacy and merits are pinpointed, and provide the basis for further inquiry into metacognitive-dialogical possibilities in treatment.

The article presents a theoretical model based upon and expanding the concepts derived from cognitive and metacognitive models applicable to the treatment of trauma and PTSD. The proposed paradigm is integrative of psychological and theological principles. A theoretical analysis of metacognitive processes such as monitoring and regulation of internal dialogues, and the employment of internal rhetoric addressing negative styles of thinking in trauma and PTSD, are addressed in the paper. This perspective may guide the efforts necessary to employ purposive, feedforward control systems that may superpose a hopeful and regulatory response style vs. traumatic aftereffects characterized by negative reactions. The practice of these

new styles of metacognitive processing – including faith-based beliefs and values – may develop and consolidate as new metanarratives allocated in the ontological, structural basis of personhood. From such top-down perspective, the person may be able to mindfully monitor, regulate, and purposefully decide on a better course of action. Practical guidelines are provided, regarded as being concrete applications of the proposed theoretical model.

Key words: *Metacognition; top-down executive control systems; detached mindfulness; purposive mindfulness; feedback control systems; feedforward control; internal dialogues; internal rhetoric; theological-psychological integration.*

The Problem. Cognitive-behavioral approaches have proved to be effective in the treatment of trauma and PTSD. These approaches have emphasized the cognitive aspects and the content of negative automatic thoughts and schemas associated with traumatic events. Remedial aspects usually have included the empowering of a patient's capacity to deal with their aftereffects by means of cognitive processes – monitoring, appraisal, regulation, and replacement of these automatic thoughts – seen as the causes underlying the negative emotions and reactions associated with them. Linear logic, template matching, and serial processes seem to characterize such treatments – bottom-up processes focusing on cognitive events cast in a play-by-play format – aimed at countering natural fight-flight reactions triggered by negative stimuli.

An analysis of metacognitive processes related to psychological trauma can provide a better explanation of what causes patients to become locked into repetitive and unhelpful cycles. These cycles appear to be self-confirmatory and reinforcing of maladaptive thoughts, feelings, and behaviors. The top-down executive control mechanisms of a traumatized patient need to be assessed and empowered so that the person may become aware, monitor, and regulate his/her negative styles of thinking, feeling, and behaving. Beyond the content of negative thoughts – events – a metacognitive-dialogical approach may address the person's schemata consolidated into metanarratives – styles of processing internal dialogues of the self – aimed at the empowering of the patient's internal persuasive rhetoric and choice of purposive responses to such.

The Analysis of the Current Research and Publications.

Post Traumatic Stress Disorder (PTSD) is a diagnostic category that defines the array of symptoms that persist for a month or more after a

traumatic event in the life of a person has occurred [1, p. 271-280], and fulfill the criteria established for such condition. The criteria include the re-experiencing of recurrent and distressing recollections, images, thoughts, and perceptions; distressing dreams, nightmares, and rumination with intense distress and physiological reactions on exposure to reminders of the traumatic event.

Metacognitive approaches have proved to be effective in the treatment of PTSD [2, p. 365-377; 3, p. 307-318; 4, p. 85-92].Metacognition is «knowledge about knowing» [5,p. 906-911). Such awareness emerges in a top-down executive process, becoming available to one's own scrutiny. Metacognition is a necessary antecedent to mindfulness. The concept «mindfulness» has been utilized in diverse forms by different authors [6; 7; 8; 9] Mindfulness-based techniques are found in therapeutic approaches, such as Acceptance and Commitment Therapy (ACT) [10], and Dialectical Behavior Therapy (DBT) [9]. Both detached mindfulness (the intentional, accepting, and non-judgmental focus of one's attention on the thoughts, sensations, and emotions occurring in the present moment registered in a feedback loop) and purposive mindfulness (the feedforward control system of the executive function, acting in a superposed and directed intention toward a goal, engaging a choice of response), are potential capacities of a metacognitive-dialogical mindset. Thus, metacognition is a style of processing information that denotes the awareness of processing and understanding one's own processes.

The concept of a dialogical self adds to metacognition in the sense that our subjective processes enter into our attentive, perceptive, attributive and regulatory functions, expressed in internal dialogues or self-talk [12, p.23-33; 13, p.31-50; 14, p. 95-107]. Such dialogues are loaded with appraisal, deliberation, evaluation, and attribution of meaning to the reality being processed. Essential to this model is the postulate that our mindfulness about the servomechanisms that allow the shift from our internal dialogues to internal rhetoric [15; 16], prompts us to persuade ourselves to make decisions, and to act on a given choice of response. Metacognition is also employed in the processing of our automatic emotional reactions by monitoring and regulating both our normal and abnormal emotional experiences.

The Purpose of the Article. The author proposes a metacognitive-dialogical model that is based upon and goes beyond cognitive-behavioral therapy (CBT) and dialectic behavior therapy (DBT). The aim of

modifying maladaptive metacognitive styles based upon ontological beliefs rather than the content of automatic, elicited negative thoughts guides the development of the proposed model in this article. The concept of a dialogical self is integrated to metacognitive notions, appealing to internal shifts from deliberative, ruminative, and self-defeating processes into more purposeful internal rhetoric and self-efficacy/control.

Main Material Presentation. Before offering a metacognitive-dialogical model, it is useful to present the nature of the dimensions of a cognitive-emotive attributive style (CEAS) of processing traumatic events. These include perseveration (characterized by worry, future anticipatory anxiety); rumination about the past, threat monitoring of possible dangers to self (increased attention to potential danger in order to reduce risk of exposure, scanning of the environment and the situation with hyper-alertness, hyper-vigilance); generalization (spreading the radius of possible threats to associations to any stimuli present during the traumatic event); repeated checking (as in OCD); maladaptive self-regulatory coping behaviors (avoidance of situations which ironically reinforce the entrenched negative associations to original stressors); suppressing intrusive thoughts with negative-attention, stimulus-bound attachments.

Besides, inadequate behavioral measures may be noticed, such as resorting to alcohol and drugs to mitigate the anxiety and deal with physiological correlates – muscle tension, agitation, irritability, tremors, bruxism. Also, self-inflicted pain –cutting, burning, or checking pulse to ascertain the fact that one is alive, or to control one's private world vs. being controlled by others or circumstances.

Often, a person may show regret with guilt/shame, marked by a desire to close memory gaps (in Gestalt fashion). Expressions such as «If only I had done….» may represent attempts to recast memories into some logical sense, trying to fit an explanation, a reason, etc., plus negative interpretations driven by a cognitive consistency related to finding a peace of mind.

Metacognitive beliefs. A traumatized person may hold deep seated beliefs that the engagement of given styles of processing will prepare him/her to deal with PTSD: worry, threat monitoring, rumination, gap-filling, and control of trauma-related thoughts; looking for some meaning to explain the trauma. Unconscious processes –dreams, nightmares, employment of defenses –add to the more obvious and conscious processes. Theological explanations belong to this domain, specially

related to the theodicy question. Theodicy is a theological construct that attempts to justify or vindicate God. It emerged in response to the evidential problem of evil that seems to contradict the existence of an omnipotent and omnibenevolent God [11, p.10].

The basic beliefs, assumptions and essential convictions/doubts entering into tacit or personal stances adopted in explanatory processes related to the past trauma, and to the anticipatory dispositions held in facing the present/future.

Faith –in God as a provider, sustainer, empowering, good Father, whose will is ultimately good, working through contingencies along the process of transforming and conforming the human to his will and purpose. Or, negative images, apprehensions, doubts, and idiosyncratic convictions that God was not there, that he does not care, or hat he allowed circumstances to serve in a punitive way,

A Metacognitive-Dialogical Model

This model expands on the cognitive notions proposed by Beck [17], expanded to metacognitive aspects by Wells and his associates [2; 3; 4; 7]. It adds the dimensions of a dialogical [12, p.23-33; 13, p.31-50; 14, p. 95-107] and rhetorical self [15;16] Trauma evokes internal survival objectives by forming a metacognitive plan that may guide cognitive processes and actions in facing present flashbacks, memories, or triggered reactions, or possible encounters with similar stressors in the future.The surge, formation, and consolidation of such schemata is influenced, shaped, and reinforced by the tacit experience of symptoms – physiological (hyper-aroused startle reactions, muscle tension, shakiness), cognitive (hyper-alertness, hyper-vigilance, dreadful thoughts intrusion, morbid rumination, worry, anticipatory anxiety), emotional (anxiety, depression), and spiritual (theodicy questions, doubts about God's care, protection, abandonment).

The automatic evocation serving an adaptive function proceeds along learned, entrenched, or conditioned lines. The person's coping styles determine whether such initial reactiveadaptation results in amelioration, subsiding and control of the automatic reactions, or becomes exaggerated, is catapulted, and engages in a negative feedback loop that reinforces the dysfunctional coping styles. The metacognitive-dialogical model is depicted diagrammatically in Figure 1. The assumption is made that a person's customary coping style relies on a cognitive-emotive attributive style (CEAS) consolidated into schemata that serve an adaptive function in automatic fashion.The aim of a traumatized per-

son is to anticipate, prevent, and prepare for a functional response to any threat. The development of such stance receives the input of physiological symptoms, attentive and orienting preparedness, exaggerated monitoring, and an apprehensive disposition.The CEAS interferes and superposes a negative interpretation of symptoms, by augmenting the value and meaning of experienced stressors, triggering fast thinking – marked by negative internal dialogues– and diminishing the person's perception of self-efficacy, control, and ability to cope. Instead of adaptive, exaggerate reactions follow.

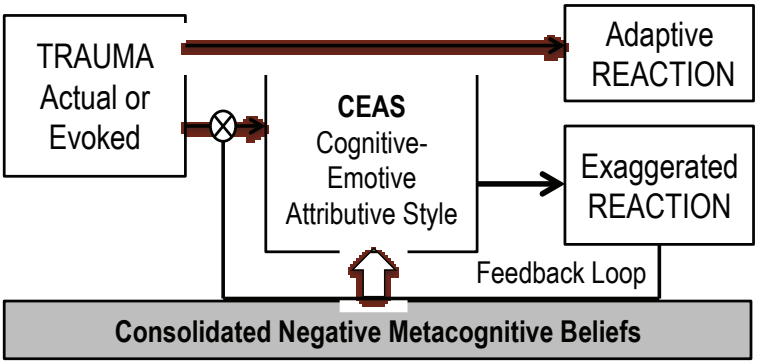

Figure 1. A metacognitive model of PTSD

The CEAS triggers a negative feedback loop –a relentless, repetitive, consolidated, and locked mechanism– tinted with obsessive-compulsive tones, and reinforces the dwelling on the negative events as well as anticipating future threats. Such negative feedback loops tend to reinforce the associations to the trauma, and sensitize the person to be more vulnerable to present and future challenges. Such processes entrench, consolidate and maintain an anxious state of mind and associated symptoms.

The natural reactions (fast thinking, emotional arousal, physiological upheaval, fight/flight reactions) may be changed into mindful and purposive responses. The need to engage in detached mindfulness, and apply a sort of a «clutch» in order to disengage fast thinking [18], in order to stop the flow of automatic processes, and engage in purposive mindfulness, is essential. The person – a believer with adequate character formation, scriptural knowledge, and spiritual insight – may resort

and appeal to his/her top-down executive agency, empowered by God's Spirit and Word, and engage a purposivefeedforward control system that in time, through training in relaxation, detached mindfulness, and purposeful internal rhetoric, may superpose and control the base, automatic reactions. Changes into deliberate, controlled responses may be actualized in function of character formation, scriptural knowledge and application of faith-based responses.

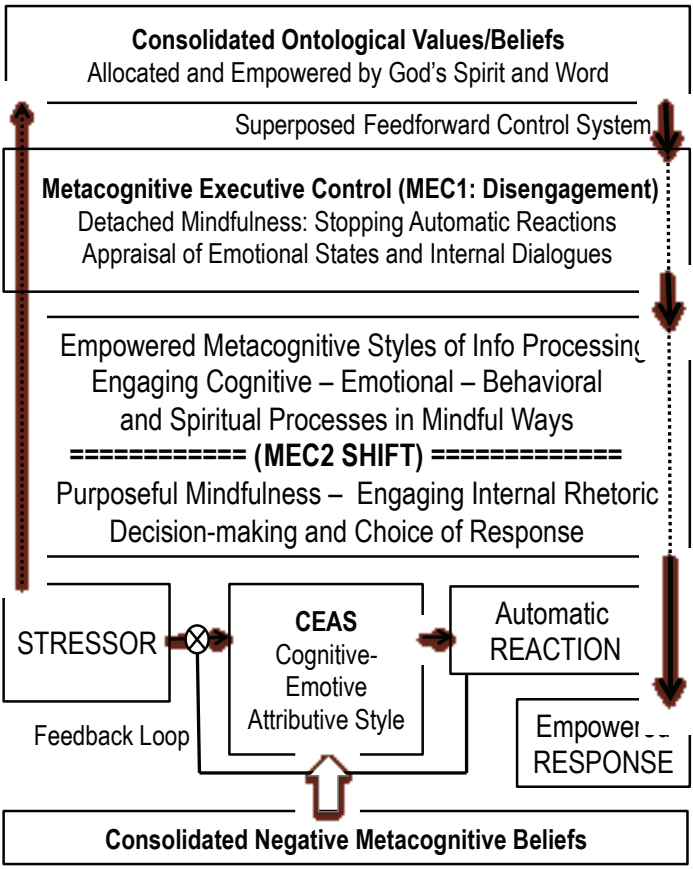

Figure 2. A metacognitive-dialogical model to treat PTSD

A Proposed Treatment Plan

The paradigm described above may include the following steps:

1. The person's character formation (spiritual maturity), and his/her level of scriptural knowledge, insight, and wisdom (in order to gear the treatment to a concordant, syntonic approach, in accordance to such spiritual variables). The research done in this area may elucidate this point [19, p.341-357; 20, p.277-290; 21, p. 64-74; 22, p. 87-108; 23; 24, 102-110; 25, p. 24-35; 26; 27, p. 24-35; 28, p. 101-111].

2. Conceptualization of the case in the theoretical framework proposed.

3. Psycho-education about the procedures, techniques, and assignments.

4. Training in metacognition –thinking about thinking, processing processes, from a higher, top-down executive perspective; becoming objective about subjective states.

5. Training in specific strategies: Detached mindfulness, Disengagement, Top-down assessment and appraisal of internal dialogues. Scriptural insights into internal dialogues [consider the Psalms in Scripture: e.g., Ps 27:5-9; 13-14; 30:6; 31:13-15; 32: 3-5; 39:1-4; 42:1-11; 55:1-9; 57:8-9; 77:1-13; 94:18-20; 102:24-28; 103:1-6; 104:33-35; 118:5-8; and passages in the New Testament, such as Luke 12:16-20; Luke 15:11-32].

6. Shift to purposive mindfulness, internal rhetoric; challenging metacognitive negative styles; empowering decision-making and adoption of choice of responses. Scriptural insights into internal rhetoric [as exemplified in the previous point].

7. Appeal to faith-based values, beliefs – Reliance on God's Spirit and Word: Faith as a superposed, feedforward control system based upon propositional truth, accepted and embedded in values and beliefs.

8. Scriptural assignments – Spiritual growth, knowledge, insight, wisdom along a theology of suffering, stress inoculation training, superposed aspects of metacognitive-dialogical perceptions, stances, and coping styles.

9. Empowering self-efficacy [29] – Relaxation training; self-talk (internal dialogues/inner rhetoric); positive coaching; modeling/observational learning. Scriptural aspects of meditation, self-efficacy under mindful control, and the existential awareness of God's presence.

10. Developing and reinforcing new plans for processing internal states of mind, physiological states, and faith-based stances (vs. wishful thinking, fiction, or self-suggestion).

11. Stress-inoculation training [30] and relapse prevention procedures: Psychological and spiritual-scriptural aspects.

12. Consolidation of gains, self-assessment

13. Follow up

Conclusion. This paper has expanded the metacognitive approaches applicable to the treatment of PTSD, by integrating the concept of a dialogical self, and drawing upon spiritual aspects of Christian faith applicable concrete fashion. The proposed model may be useful in cases involving believers who in intrinsic fashion can utilize their faith in facing their symptoms, moving beyond the entrapments of negative mindsets, idiosyncratic theological takes reinforcing helplessness, or the adoption of a stance on suffering marked by intropunitiveness or destiny. From a victimized stance, the person may be empowered to consider a more positive and functional disposition, and be able to employ scripturally-based acceptance of reality, develop self-worth, and employ faith-based fight responses, coupled to mindful detachment and purposive internal rhetoric.

References:

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). Washington, DC: American Psychiatric Association. – 2013 – p. 271–280.

2. Wells, A. &Sembi, S. Metacognitive therapy for PTSD: A core treatment manual. Cognitive and Behavioral Practice. -2004a – Vol11, 365–377.

3. Wells, A. &Sembi, S. Metacognitive therapy for PTSD: A preliminary investigation for a new brief treatment. Journal of Behavior Therapy and Experimental Psychiatry. -2004b – Vol35, 307–318.

4. Wells, A., Welford, M., Fraser, J., King, P., Mendel, E., Wisely, J., et al. PTSD treated with metacognitive therapy: An open trial. Cognitive and Behavioral Practice. – 2004b – 15,p. 85–92.

5. Flavell, J. H. Metacognition and cognitive monitoring: A new area of cognitive-developmental inquiry. American Psychologist. 1979 – Vol 34, 906–911.

6. Langer, E. Counterclockwise: Mindful health and the power of possibility. New York, NY: Ballantine Books. 2009.

7. Wells, A. Metacognitive Therapy for Anxiety and Depression. New York: NY: Guilford. 2009.

8. Kabat-Zinn, J. Mindfulness meditation for everyday life. New York: Harperion. – 1994.

9. Linehan, M. M. Skills training manual for treating borderline personality disorders. New York, NY: Guilford. -1993.

10. Hayes, S. C., Strosahl, K. D. & Wilson, K. G. Acceptance and commitment therapy: An experiential approach to behavior change. New York, NY: Guilford. 1999.

11. Plantinga, A. God, Freedom, and Evil. Grand Rapids, MI: Eerdmans – 1974 – p.10.

12. Hermans, H. J. M., Kempen, H. J. G..,& Van Loon, R. J. P. (1992). The dialogical self: Beyond individualism and rationalism. American Psychologist, 1992 – Vol 47 – 23-33.

13. Hermans, H. J. M. (1996). Voicing the self: From information processing to dialogical interchange. Psychological Bulletin. – 1996 – Vol 119, p. 31–50.

14. Polischuk, P. (1998). Perspectives on the self: Substantial and dialogical aspects. Perspectives in Faith and mechanism in human agency. American Psychologist – 1982 -Vol 7, No 2. – 122–147.

15. Polischuk, P. A Metacognitive Perspective on Internal Dialogues and Rhetoric:Derived from the Details of the Prodigal Son's Parable. The Journal of Psychology and Theology. (In press, Spring 2015)

16. Nienkamp. J. Internal Rhetorics: Toward a history and theory of self-persuasion. Carbondale, IL: Southern Illinois Press. 2002.

17. Beck, J. & Beck, A. Cognitive therapy and beyond. 2nd. Edition. New York, NY: The Guilford Press. 2011.

18. Kahneman, D. Thinking, fast and slow. New York, NY: Farrar, Strauss, and Giroux. 2011.

19. Hall, T. W., & Edwards, K. J. (2002). The Spiritual Assessment Inventory: A theistic model and measure for assessing spiritual development. Journal for the Scientific Study of Religion – 2002. – Vol 41, p. 341–357.

20. Hall, T. W. & McMinn, M.R (Eds.). Spiritual Formation, Counseling, and Psychotherapy. New York: Nova Science. – 2003 – p. 277–290.

21. Hill, P. C, &Pargament, K. I. Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. American Psychologist. – 2003 -Vol58, p. 64–74.

22. Hill, P. C. Spiritual transformation: Forming the habitual center of personal energy. Research in the Social Scientific Study of Religion. -2003 -Vol13, p. 87-108.

23. Jeeves, M. Minds, brains, souls, and gods: A conversation on faith, psychology and neuroscience. InterVarsity Press. -2013.

24. McMinn, M. R., &McRay, B. W. Spiritual disciplines and the practice of integration: Possibilities and challenges for Christian psychologists. Journal of Psychology and Theology – 1997 -Vol25, 102-110.

25. Miller, W.R., &Thoresen, C.E. (2003). Spirituality, religion, and health: An emerging research field. American Psychologist – 2003. – Vol58, p. 24–35.

26. Pargament, K.I. The psychology of religion and coping: Theory, research, and practice. New York: Guilford. 1997.

27. Tan, S. Y, & Johnson, W. B. Spiritually-oriented cognitive-behavioral therapy. In L. Sperry & E. P. Shafranske (Eds.), Spiritually-oriented psychotherapy.Washington, DC; American Psychological Association. – 2005 – p. 77–103.

28. Tan, S-Y. (2007). Use of prayer ands Scripture in cognitive-behavioral therapy. Journal of Psychology and Christianity. – 2007. – Vol 26 No. 2, p. 101–111.

29. Bandura, A. Self-efficacy: The exercise of control. W. H. Freeman. 1997.

30. Meichenbaum, D. Stress inoculation training. – Elmsford, NY : Pergamon. 1985.